EXAMINING COLLABORATION WITHIN CHILD WELFARE MULTIDISCIPLINARY TEAMS: HOW HOME-BASED THERAPISTS RESPOND TO CONFLICT

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DEDICATION

This work is dedicated to my wife, Molly, and my three children, Cora, Nolan, and Declan for all their love and support throughout this journey. I would not be getting my PhD without Molly who has been immensely helpful during all these years. Whether it was urging me to apply to this program, watching the children on the weekends so I could do work, working full-time so we could support our family, proofreading papers, encouraging me when I began to doubt myself or get frustrated, or just listening to me talk about my research and getting excited with me, I could not imagine a better partner and friend. I am so excited to be done and to all you, we can finally have weekends all together without me doing work!

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EXAMINING COLLABORATION WITHIN CHILD WELFARE MULTIDISCIPLINARY TEAMS:

HOW HOME-BASED THERAPISTS RESPOND TO CONFLICT

When the child welfare system becomes involved with a family in need of services it does so with the goal of concluding its involvement by finding a safe and permanent placement for the children, ideally with their parents. This challenging and complicated work often has many issues that need to be addressed before a successful closure can occur. To achieve this goal, multiple service providers with various backgrounds, degrees, and professions are tasked with working with each other and the family through a collaborative team called a multidisciplinary team (MDT). However, collaboration is not always guaranteed, and conflict can emerge as the team attempts to best serve the family. This conflict may emerge among professionals and between professionals and the family. Although the underlying factors of collaboration and conflict have been documented and studied, research on the process of resolving conflict when it occurs in MDTs is severely lacking in the literature. Furthermore, MDTs specific to the child welfare system also lack the focus they deserve within the child welfare literature. This grounded theory study addresses the gap by focusing on child welfare MDTs and specifically on home-based therapists (N=20) to determine not only their perceptions of facilitators and barriers to collaboration but also the process that they and their fellow service providers engage in when addressing and resolving conflict. In conducting this qualitative study, this researcher used grounded theory to construct a theory outlining the processes that home-based therapists utilize to resolve conflict within

MDTs, starting with the emergence of the conflict and detailing the decision making process through the team's reaction and the ultimate decision or final result. In the future, these findings could be used to aid and train other MDT members as they face their own conflicts with the hope that a more efficient conflict resolution process will lead to a more effective MDT that keeps its focus on the family and provides the needed treatment and services in a timely manner.

Barbara Pierce, PhD, Chair

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LIST OF ABBREVIATIONS

CPPC	Community Partnerships for Protecting Children
CASA	Court Appointed Special Advocate
DCS	Department of Child Services
FCM	Family Case Manager
FGC	Family Group Conferencing
FGDM	Family Group Decision Making
GAL	Guardian ad litem
MDT	Multidisciplinary Team
TDM	Team Decisionmaking

Chapter I: Introduction

Families involved in the child welfare system are often in crisis. This is a stressful time for the families involved who often have complicated issues that need immediate attention in order to be resolved in a safe and timely manner. This work requires multiple professionals all working toward the goal of helping the family attain safety, permanency, and well-being for the children. To aid in this effort, these professionals work in collaborative teams consisting of multiple professionals with multiple backgrounds who "work together, making a different, but complementary contribution to client care" on the multidisciplinary teams (MDTs) as the case progresses (Caldwell, Atwal, Copp, Brett-Richards, and Coleman, 2006, p. 1252). This definition is one of the better fits in the literature for child welfare MDTS as it highlights the different professionals involved and their individual work that collectively can aid the family. As such, this definition will be used in this dissertation. MDTs consist of several different professionals including those representing the fields of child protection, mental health, medical care, law enforcement, and prosecution (Johnson, 2013).

This study will focus on the child welfare system and ways in which multidisciplinary child welfare teams factor into the progression of a case and will have a particular interest in the facilitators and barriers of the team collaboration as well as the causes, impacts, and strategies to overcome conflict among team members. Multidisciplinary child welfare teams are made up of many different service providers tasked with serving families involved in the child welfare system. Their purpose is to ensure all team members are working efficiently and effectively for and with the family while not duplicating any services so that the family receives all of their needed services

in the most effective manner. MDTs are increasingly used in the child welfare system (Lalayants & Epstein, 2005) and workers report that conflicts arise among members quite frequently (De Dreu & Weingart, 2003; de Wit, Greer, & Jehn, 2012; O'Neill, Allen, & Hastings, 2013). Therefore, understanding effective practices and theories regarding multidisciplinary collaboration and conflict resolution is essential to evaluating the child welfare system and how it serves families in need of services.

Background

Conflicts among participants in child welfare MDTs can and do occur and when they do they have the potential to take the focus away from their ultimate goals of ensuring that children have a safe and permanent place to live and grow, ideally with their family (Indiana Department of Child Services [INDCS], 2014; US Department of Health and Human Services [USDHHS], 2019). Attachment between children and their parents is critical and valuable in our child welfare system and society as a whole so attaining a safe and timely reunification is important in reducing the negative effects that trauma and lack of attachment may produce in the children and families as a whole. Multiple service providers are charged with this task. As a certain level of collaboration is required in order to work effectively with each other and for the family, the study of collaboration and conflict within MDTs is an important undertaking. As will be illustrated below, much is known about the elements of collaboration and why conflicts arise, but little is known about how the team members resolve these conflicts once they occur. Conflicts can lead to a breakdown in collaboration and communication, which appear to be vital to a successful MDT (Johnson, 2013). Alliances can form based on disagreements (Northrup, 1989) and once this occurs, there is the potential for a

dangerous process of inclusion and exclusion to occur among the alliances with each group developing an inner core that is critical of the other (Hood, 2015).

Children and families deserve effective treatment, especially when there is the potential for parental rights to be terminated. For social workers, providing effective treatment is not only good practice but also a core value of the profession as part of the National Association of Social Worker's (NASW) *Code of Ethics* (2008). Unresolved conflict among services members is counterproductive to this value and thus needs to be addressed. As such, conflict management in MDTs is vital in assisting families not only to navigate the child welfare system but to come out of it with the desired result.

Before examining MDTs and the role of conflict among their service providers more closely, it is important to understand the larger system in which they operate. The child welfare system as a whole is vast and complex involving hundreds of thousands of families each year (USDHHS, 2019). These families must comply with team recommendations and court orders to complete specific services. The level of involvement, services, and orders vary greatly, as do the causes for involvement and the outcomes. A brief description below provides the context in which child welfare MDTs and their team members operate.

Historical Context

The history of the child welfare system is one of conflicting views. States have been involved in families' lives and the lives of their children prior to the advent of any formal child welfare system. In 1851, Massachusetts passed a law that would come to be known as the Massachusetts Adoption Act. This law required courts to approve adoptions and required written consent of birthparents. This was part of a movement to decrease the

use of institutions for children who needed permanent placements. However, shortly after the passage of this bill another development occurred as Rev. Charles Loring Brace started what would be known as the "orphan trains." This movement saw children, many of which were not orphans, shipped to families all over the Midwest via train. Brace did not always get consent from the children's parents and believed that they were not the best parental options for their children (Kahan, 2006).

The orphan train system continued into the 1900s, but a counter movement grew in which advocates argued for family preservation at all costs. This led to the U.S Children's Bureau and other family programs in the early 1900s (Kahan, 2006). Orphan trains eventually became a thing of the past as more services and programs were implemented to help struggling families remain intact. In recent history, the child welfare system sought a balance between keeping families of origin intact and ensuring child safety. This balance can be seen in acts like the Adoption Assistance and Child Welfare Act of 1980 (Berrick, Choi, D'Andrade, & Frame, 2008) and the Adoption and Safe Families Act (AFSA) of 1997 (Allen & Bissell, 2004; Berrick et al., 2008; Davidson, 2008; McGowan & Walsh, 2000) which will be discussed in greater detailed in a later section.

Child Welfare Involvement

The United States Department of Health and Human Services (2016) lists several different types of child maltreatment that can result in a family having an open case with the child welfare system. These types of maltreatment include neglect, physical abuse, psychological/emotional abuse, sexual abuse, and medical neglect. Removal is required when there are safety concerns for the children. When children are removed, they are

placed in foster care, relative or kinship care, or a residential facility depending on the level of need. A licensed foster parent who typically has no prior relationship with the child provides foster care. Relative or kinship care is placement with a relative or, in some cases, a family friend. Residential placement is less common but is used if the child's behavior or medical conditions require more intensive services than could be provided by the other placement options mentioned. During the removal process, the parents are involved in services, visitations, and regular court proceedings. Cases remain open until they are resolved which may occur by reunification, termination of parental rights, or another permanency plan such as guardianship or emancipation (Child Welfare Information Gateway, 2006; INDCS, 2014).

The child welfare system strives to ensure a timely, successful, and most importantly, long-lasting reunification while protecting the safety of the child. The system attempts to keep families intact and many families are able to address concerns with proper services. However, in some cases, reunification is not always possible or even appropriate. Families involved in the child welfare system have varying characteristics including race, income, age, and number of children (USDHHS, 2019). Substance abuse, domestic violence, and mental health issues are common struggles for parents involved in the child welfare system (Marcenko, Lyons, & Courtney, 2011). Issues of past trauma are also prevalent (Blakey & Hatcher, 2013; Marcenko et al., 2011) as are issues related to unemployment and the cycle of poverty (Marcenko et al., 2011).

The child welfare system provides services of varying intensity and delivery methods to parents (Chaffin, Hecht, Bard, Silovsky, & Beasley, 2012). These services are aimed at addressing the plethora of issues families in the child welfare system struggle

with and include child abuse and neglect, domestic violence, drug use, trauma, and issues related to poverty (Child Welfare Information Gateway, 2006). Common services across the country are individual and family therapy, case management, parent aid services, substance abuse treatment, domestic violence classes, and supervised visitation (Child Welfare Information Gateway, 2006). Another common practice is to refer parents to classes that address the reasons for removal or a barrier to reunification such as domestic violence or substance abuse classes. Families can also be referred to more general services like parenting classes and counseling (D'Andrade & Nguyen, 2014). Home-based services may also be ordered and can include therapy and/or case management.

These different services are implemented by a variety of professionals with varying educational degrees, backgrounds, and responsibilities. These professionals make up the child welfare multidisciplinary team. With multiple services becoming the norm it is not surprising that MDTs have grown in popularity over the past several decades and have become an important part of the child welfare system (Lalayants & Epstein, 2005). Multiple professions attempt to work together to provide effective services for families as they address issues that have resulted in their involvement with the system. Collaboration is important for successful outcomes, but MDTs can experience friction and conflict can arise among team members at times as will be discussed in greater detail.

Overview of the Child Welfare Population

The U.S. Department of Health and Human Services created Child Welfare Outcome Reports to provide information to Congress about state and national performance regarding the operation of the child welfare and child protection programs, as indicated by seven outcomes focused on child abuse and neglect, placement options,

and permanency (USDHHS, 2019). These seven outcomes are: reducing the recurrence of child abuse and/or neglect, reducing the incidence of child abuse and/or neglect in foster care, increasing permanency for children in foster care, reducing time in foster care to reunification without increasing reentry, reducing time in foster care to adoption, increasing placement stability, and reducing placements of young children in group homes or institutions (USDHHS, 2019). Using the most recent report to Congress, approximately 437,000 children were in the foster care system on the last day of 2016 (USDHHS, 2019). Overall, for 2016, approximately 48.3% of the children in foster care in the United States were white, 17.5% were Black, and 9.1% were Hispanic. The remaining percentages were made up of biracial children and children belonging to other races/ethnicities. About half (50.8%) of the children in foster care nationwide were under 7 years old and 14.7% were 16 or older (USDHHS, 2019).

Reunification is by far the most likely outcome when a child becomes involved in foster care as 56.9% of foster care cases ended in reunification in 2016. Additionally, a national average of 66.1% of all children reunified with their parents or caretaker were reunified within the first 12 months with the average length of stay was just under 8 months. However, in that same year, 6.8% of those children reentered the foster care system within a year of their discharge when using the median rate across all states. In the state of Indiana, only 4.8% of children in foster care were there as a result of reentry within the last 12 months. (USDHHS, 2019).

MDTs

MDT is not the only term used to describe interprofessional teams. A literature search about interprofessional collaboration completed by D'Amour, Ferrada-Videla,

Rodriguez, and Beaulieu (2005) highlights the importance of defining interprofessional as the authors found that various terms, which are often not well defined and are often used interchangeably, are used throughout the literature. The three most frequently used terms to define teams made up of different professions or disciplines are multidisciplinary, interdisciplinary, and transdisciplinary. D'Amour et al. (2005) attempted to differentiate these terms and do so as it relates to the level of integration within the team. MDTs are the least integrated as members work independently or in parallel. Members might not even meet in person but still work in a coordinated fashion. This important distinction of MDTs contrasts with the more integrated forms of interprofessional work, which seek to obtain common decision-making processes or even consensus. Since, not all members of MDTs will have the same goals, decision-making process, or information to assist in decisions, multidisciplinary appears to be the most appropriate term to use in referring to the child welfare teams that work for families to achieve permanency and improve child well-being. Guardians ad litem (GALs) are focused on ensuring that the children receive strong advocates and as such may have different information and goals than a therapist who only provides services for the parent and might not be privy to the what the child is sharing with the GAL.

MDTs have been a part of the child welfare system since the 1950s and can be found in most states (Jacobson, 2002). MDTs have become very popular over the last several decades (Lalayants & Epstein, 2005) and the collaborative element that accompanies them is frequently identified as a necessary component of effective child welfare practice (Han, Carnochan, & Austin, 2008; Jones, Packard, & Nahrstedt, 2002; Lalayants, 2013; Nicholson, Artz, Armitage, & Fagan, 2000; USDHHS, 2019). Many

studies have attempted to identify the elements of interagency collaboration in the child welfare system and how it may benefit children and families (e.g., Bai, Wells, & Hillemeier, 2009; Chuang & Wells, 2010; Chuang & Lucio, 2011; Foster, Wells, & Bai, 2009; He, Lim, Lecklitner, Olson, & Traube, 2015; Hurlburt et al., 2004).

MDTs in the child welfare system are theorized to be more effective in achieving outcomes, more accurate when assessing and predicting risk and when outlining appropriate interventions, more likely to reduce trauma levels in children, and to increase the quality of evidence in cases where criminal charges must be filed. They are also more effective in providing support to stressed and exhausted professionals. Finally, using MDTs can reduce issues such as fragmented service delivery, role confusion, and duplication of services (Lalayants & Epstein, 2005).

According to Kaminer, Crowe, and Budde-Giltner (1988) MDTs can be organized into four main types: 1) treatment teams, 2) case consultation teams, 3) resource development or community action teams, and 4) mixed model teams. Treatment experts along with the child welfare worker and the families form treatment teams, and are responsible for case assessment, diagnosis, treatment planning, referral to treatment, and case follow up. Case consultation teams act as advisors on cases to the primary caseworkers to assist in treatment planning and critical decisions. Resource development or community action teams consist of service providers, child advocates, and citizens who work to address local problems associated to child abuse and neglect. Finally, mixed model teams combine two or more of the team functions. The focus of this dissertation is on treatment teams as this best describes a typical child welfare MDT within in the area in which the participants practice.

Within the team, each member has a different task and potentially a different client such as parent or separate parents, and different children. The child welfare caseworker is responsible for the service referrals, placement options, court reports, and ensuring the family is following all court orders, among other things. Other team members, such as GAL or child advocates, are tasked with representing the child's or children's voice to the team and the courts. Other providers may receive referrals to provide specific services such as substance abuse treatment, domestic violence counseling, or parenting education. Home-based case management and therapy are also likely services to be implemented. A home-based therapist will provide therapy to a parent, child, or entire family within the home, seeing them on a regularly scheduled basis and helping the client(s) to address therapeutic needs ranging from sexual abuse to parenting skills. Each service provider is part of the family's child welfare team and reports to the family's child welfare caseworker. The entire team must work together to help the family achieve its goal of reunifying and address needed issues with the hope that the family will no longer need the involvement of the child welfare system (Child Welfare Information Gateway, 2006).

Home-Based Therapists

Home-based therapy has become a popular means to provide therapy (Reiter, 2000; Worth & Blow, 2010). This form of therapy has a long history in social work and has taken different forms as its popularity has fluctuated (Allen & Tracy, 2008). Providing services to people in the home setting for social work as an established service delivery method began with Mary Richmond (1899) as written in *Friendly Visiting Among the Poor.* Home visiting spread in the early 1900s only to see it lose momentum

as social workers began to attain professional status. This movement then led to transferring the work of home-based services to paraprofessionals. However, social workers in schools and the child welfare field continued to utilize clients' homes as a means to deliver their services (Allen & Tracy, 2008).

Home-based therapy, along with other home-based services, had a resurgence starting in the 1980s with the passage of family preservation legislation such as the Adoption Assistance and Child Welfare Act of 1980 (Chistensen, 1995) and the Family Preservation and Support Services Program (PL 103-66) (Allen & Tracy, 2008). This resurgence was particularly impactful in the child welfare setting as home-based services and programs were viewed as alternatives to out-of-home care (Christensen, 1995).

Home-based therapy is often used to assist families with multiple issues including substance abuse, domestic violence, child abuse, and mental health issues (Adams & Maynard, 2000). These issues are commonly found in families involved in the child welfare system (Marcenko et al., 2011), making a home-based therapist a common and vital team member on child welfare teams (Allen & Tracy, 2008). Home-based therapists are also vital members because they are given the challenge of addressing therapeutic needs of individual family members or, in some cases, the entire family. Their constant contact with families, higher level of education, and experience as a therapist makes them a likely leader within the MDT. As a result, their view of collaboration and ability to resolve conflicts may serve to enlighten others about practice in MDTs.

As home-based therapy and MDTs have become common in child welfare practice it is necessary to examine how home-based therapists view collaboration and specifically how they resolve conflict within the team. This specific subject has not

warranted much attention from the research community though several studies might be able to be generalized to home-based therapists. Frost, Robinson, and Anning (2005) examined social workers' roles in MDTs but did not specify the exact role of the social worker within the team (therapist, case manager, substance abuse counselor, etc.). Brown et al. (2011) provide an examination of conflict including causes and solutions but do so using a primary health care team. Although these studies are beneficial, their focus is not on how an individual team member is able to navigate the barriers that are associated with MDTs and successfully resolve conflicts that emerge to best serve the family involved in the child welfare system. As a result, this researcher used grounded theory to explore and analyze how home-based therapists resolve conflicts within their child welfare teams in the hopes to develop a better understanding of this needed process. This process is important because it allows the team to resolve conflict effectively and continue to focus on the needs of the family. There were multiple reasons the researcher chose home-based therapists is because they are a vital member of the team, often seeing their clients the most out any team member as they see their clients once a week in their homes. Home-based therapists are also often the ones with the highest degree and specialized training out of all team members. Finally, as this researcher is interesting in the training and education of social work students, it seemed important to focus on the team member that would mostly likely have a degree in social work. For the studied area, home-based therapists must have at least a master's degree that allows them to practice therapy. While this does not have to be an MSW, it is a common degree among practicing home-based therapists. For these reasons, the home-based therapist was deemed to team member on which to focus for this particular study.

Child Welfare Policies that led to MDTs

In 1980, Congress passed the Adoption Assistance and Child Welfare Act, which stated that "reasonable efforts" were to be made to keep children from foster care or reunify families if children were removed. However, fearing that these efforts of keeping families together would overpower concerns for the child safety, Congress decided to lessen its stance on family preservation as the main goal (Berrick et al., 2008), recognizing that sometimes children's families of origins are not always safe or appropriate for them. Thus, a more balanced approach in which family units are respected but child safety is the main priority became the driving force behind one of the most recent and expansive child welfare policy, the Adoption and Safe Families Act (AFSA) of 1997. The AFSA sought to address issues of child safety and long-term stays in the foster care system by decreasing the time in which courts had to hold permanency hearings from 18 to 12 months and required states to initiate terminations of parental rights after a child was in the state's care for 15 of the last 22 months (Allen & Bissell, 2004). However, in acting according to the goal of a safe and timely reunification, this act also expanded services to birthparents (Allen & Bissell, 2004).

With ASFA, safety and permanency became and are now the primary focus for the professionals involved in the child welfare system. Children must now be safely reunified with their parents or find another permanent living arrangement (Davidson, 2008; McGowan & Walsh, 2000). This law also gave specific examples where the state does not have to make a reasonable effort to reunify children with their parents. Such instances involve parents who have committed murder or have previously had their

parental rights of a sibling involuntarily terminated (Berrick et al., 2008; McGowan & Walsh, 2000).

When the child welfare system becomes involved with a family, a common practice is to refer that family to services with the goal of addressing the reason or reasons for involvement so the case can be successfully closed with the family reunified and no longer needing the involvement of the child welfare system. At times, these services can be overwhelming as D'Andrade and Chambers (2012) found in their review of 139 child welfare cases. The researchers found that parents were required to attend an average of eight service events a week. This could be problematic by itself but the fact that D'Andrade and Chambers (2012) also found that 30% of the parents in the study were ordered to complete services for issues that were not indicated in formal reports raises concern. However, this fact does not account for the possibility that more issues arose during the course of the case that needed to be address. Regardless of the reason, additional services often lead to more team members and may complicate team decision-making and collaboration in general. Since safely reunifying children with parents is a primary focus, issues that precipitated the child welfare involvement must be address. As these issues have become more complex, referring families to multiple services has become the norm, which in turn has caused MDTs to gain popularity (Lalayants & Epstein, 2005).

Social Work Values Found in Child Welfare and MDTs

Social workers are often involved in the child welfare system and MDTs in one capacity or another. Regardless of the social worker's position within the system or within the team, they must conduct themselves in accordance with the NASW (2008)

Code of Ethics. Focusing on MDTs, it is clear that multiple values, ethical principles, and professional standards are relevant for social workers working within a child welfare MDT. The *Code of Ethics* (NASW, 2008) guides social workers as they work with clients, colleagues, and other professionals. Thus, the *Code of Ethics* (NASW, 2008) is extremely pertinent to those involved in child welfare MDTs.

Social workers are directed to help people in need and address social problems (NASW, 2008). MDTs do this as they assist families in time of crises and address issues and problems to help facilitate the reunification of the family and ensure the safety of the child. Social workers are also called to challenge social injustice, especially as it pertains to vulnerable and oppressed individuals (NASW, 2008). These individuals are often represented in the child welfare population. The dignity and worth of the person must also be respected (NASW, 2008). This is important as it relates to MDT work because the social worker is called to advocate for the client and promote self-determination as much possible (NASW, 2008). Having a team member with the mindset that the dignity and self-worth of clients must always be respected is crucial within the child welfare system as it may be easy for some team members to vilify parents who abuse or neglect their children, even if the parents are their clients. Although social workers would not put a child in danger by advocating for reunification with a parent who is unfit, they can provide some compassion and fairness to the conversation as difficult and life-changing decisions are discussed.

Social workers also believe in the importance of human relationships and they seek to involve people as partners in the change process (NASW, 2008). This belief pertains to clients as well as other team members. Seeing people as partners is more

conducive for collaboration to occur between social workers and other professionals and helps to eliminate power struggles and status disparities that can lead to conflict. Finally, social workers are required to behave in a trustworthy manner (NASW, 2008). This behavior benefits both the clients and the other team members because they can expect and demand behavior and practice from the social worker that promotes and is consistent with the mission, values, ethical principles, and ethical standards of the social work profession.

Social Work Ethics Found in Child Welfare and MDTs

Social workers also must abide by multiple ethical standards. Standards influencing how social workers work with and for clients make them vital team members of any MDT. A social worker must be committed to their clients, uphold self-determination, value social diversity, and display cultural competency (NASW, 2008). In doing so, social workers may often take the role of advocator or even educator within MDTs. This can lead to a more holistic view of the client as cultural and societal differences are not only brought to light but looked at from a strengths perspective.

The *Code of Ethics* (NASW, 2008) also outlines how social workers should interact and work with colleagues and other professionals. Respect is a key standard where social workers are called to not only be respectful but also avoid unwarranted negative criticism and engage in cooperation to serve the well-being of the client. The *Code of Ethics* (NASW, 2008) even has an ethical standard specially related in interdisciplinary collaboration, calling social workers that engage in such teams to do so in a way that draws on the perspectives, values, and experiences of the profession. Finally, any impairment, incompetent, or unethical conduct of a colleague needs to be

properly addressed (NASW, 2008). These standards aid in ensuring that MDTs have high standards in terms of team members and a mechanism for resolving conflict in an appropriate and professional manner. These beneficial attributes help the team remain effective and client focused.

The Importance of Understanding Conflict within MDTs

Understanding conflict, its causes, and how service providers address and deal with it is important to the child welfare system and the families it serves. Part of this understanding will also come from exploring the factors that promote and impeded collaboration. For the families who find themselves involved in the child welfare system, it is unquestionably a stressful time. These families become involved for a variety of reasons, all of which are serious enough to warrant state involvement and assistant. When considering the statutory time limits for permanency, it becomes all the more important that these services and the team tasked to work with the family need to be effective and well managed. Though not all members will work directly with each other, they all need to work together for the betterment of the family. One way service providers can do this is to effectively manage any conflict that arises among the team members. As will be shown, this area is studied more in other fields than in social work. Service providers may be well equipped to provide clients with their particular services, confront a variety of crises, or manage a difficult client but they may not be as well trained, or even trained at all, to work with other providers through disagreements in treatments or the direction of the case. Conflict management and resolution among services providers within child welfare MDTs is under study and often ignored but can be a vital part to providing effective, efficient, and ethical services to families at their greatest times of needs.

Chapter II: Literature Review

Theories Influencing MDTs

To this point, the focus of how team members work within MDTs has revolved around the polar concepts of collaboration and conflict. Continuing with this thought process, it is important to examine theories that explore and explain how and why team members will either find themselves in collaboration or conflict as they work within MDTs. This is not to say that the working relationship of an MDT has to fall into one category or the other or even that one excludes the other. In fact, an MDT may fluctuate between moments of collaboration and conflict depending on the topic or those involved. However, the larger picture and makeup of MDTs cannot be overlooked as it is important to remember that MDTs are formed with different professionals from different fields who may even at times represent different clients. As such, theories such as systems theory and role theory also factor into the exploration of the depth of MDT collaboration and conflict.

Collaboration Theory

While stressing the importance of evaluating strategic alliances, Gajda (2004) examines the collaboration literature and outlines five principles of collaboration theory. One such principle is that collaboration is imperative with an increased need for people to work together efficiently across many different professions. The second principle of collaboration theory is that collaborations can be referred to by many different names. Partnerships, networks, joint ventures, alliances, task forces, coalitions, collaboratives, associations, and groups are just some of the many names found in the literature that have been used to describe collaboration. Another principle of collaboration theory is that the

personal relationship is just as important as the procedural aspects within the group or team. As a result of this, conflict is to be expected. Positive relationships and a certain level of trust is needed to have an effective collaboration. The fourth principle of collaboration theory is that collaboration is viewed as a journey, not a destination. Finally, the fifth principle is that collaboration develops in stages (Gajda, 2004).

One principle of collaboration that derives from a great deal of scholarly attention is the notion that collaboration is to be viewed as a journey rather than a destination. Under this principle, scholars have proposed different levels of integration or degrees with which collaborations progress over time. Peterson (1991) proposed a three-point continuum of collaboration. The first level is cooperation where fully independent groups share information that support each other's outcomes. A more integrated group may reach the second level of collaboration, coordination, which occurs when independent parties align activities or co-sponsors services that support mutually beneficial goals. Finally, the most integrated group on this continuum is called a collaboration. At this level individual entities relinquish some degree of independence in an effort to achieve a shared goal.

Hogue (1994) presents five levels of collaborative relationships or "linkages": 1) networking, 2) cooperation/alliance, 3) coordination/partnership, 4) coalition, and 5) collaboration. Networking has the loosest structure but allows entities to have a dialogue, a clearinghouse of helpful information, and a means of support. Cooperation/alliances are semi-formal links and the roles of each member are loosely defined. A cooperation/alliance allows members to meet their needs, accomplish tasks, and reduce service duplication. Next, coordination/partnerships have a formalized structure with

roles defined with members both sharing and merging resources to address common issues. The fourth level, coalition, involves all members in the decision-making process and has a greater formal structure with written agreements. Members will frequently share ideas and pull resources from existing systems to accomplish goals. Finally, collaboration is the most integrated level. At this level consensus is used in shared decision-making and an interdependent system is developed by members to address issues and opportunities.

Others have extended Peterson's (1991) and Hogue's (1994) work to create a greater level of integration than collaboration. Bailey and Koney (2000) argue that coadunation, where one party completely relinquishes its autonomy in an effort to strengthen the surviving organization, should be the farthest point on the continuum. Keast (2016) provides a similar final level in consolidation where a new entity is formed, or one entity consumes another. It is important to note that in most cases these concepts and continuums of collaboration are applied to agencies not individuals. Although coadunation and consolidation cannot be applied to individual relationships the rest are applicable on an individual level and thus may appear in MDTs.

The fifth and final principle of collaboration theory that Gajda (2004) presents is that collaboration develops in stages, and like the idea of collaboration as a journey, also has a great deal of scholarly support. Here Tuckman's (1965) model of stage development is vital. First, the group most go through the forming stage where members orient themselves to the group and identify boundaries. This is done by testing limits and relying on leadership and pre-existing standards. Storming follows where members try to establish their roles. Conflict and resistance characterize this stage. Groups can use group

cohesion to overcome this resistance in the next stage, norming. As groups experience the norming stage, new roles and standards emerge and are adopted. Finally, groups obtain the performing stage when the interpersonal structure allows the group to perform its desired task. This stage had been the original final stage until Tuckman and Jensen (1977) added an additional stage of adjourning where the group dissolves or changes it purpose.

Using this model, MDTs will experience these stages as members are assigned to a case. At the start of a case there can be a period of forming as each member becomes familiar with how the other members operate. Pre-existing standards and roles can exist for each member but how those are put into effect may differ from their previous experience with MDTs. As such, there will be a storming period as service providers, family caseworker, and other members try to establish their roles in the team. Their functions are well defined but how team members view each other, their opinions, and their respective roles in terms of leadership can be decided in the infancy of the group. This will help to establish the norms of the group. These norms will be seen in terms of how team meetings are held and how members communicate with each other outside of meetings. The performing stage should then, ideally, lead to a successful termination of the case at which point the group will adjourn.

Despite the popularity of Tuckman's model in group development, there is a deficiency in the number of researchers who have empirically tested this model. Tuckman and Jensen (2010) themselves admit to this lack of testing, and state that only Runkel, Lawrence, Oldfiled, Rider, and Clark (1971) have attempted to test the model. Through their study of three groups of 15-20 college students, Runkel et al. (1971) found

support for Tuckman's original four stage model. However, this study is highly flawed as observers were told to observe and look only specifically for behaviors and actions that would fit one of the stages. Bonebright (2010) also conducted a review of Tuckman's model in search of evidence to support it and also only found Runkel et al. (1971) in support of the model. Although this lack of empirical support may cause some to question the validity of Tuckman's model, it should not necessarily cause doubt in Gajda's (2004) assertion that collaboration occurs in stages. In reviewing the literature, Tuckman and Jensen (2010) highlight multiple other models of group development occurring in stages. This work also appears to be more theoretical and the description of how an MDT will progress using Tuckman's model is a realistic description of how teams may function as they begin their work. However, due to the lack of empirical evidence, it is not clear if this occurs within child welfare MDTs. Though not the specific focus of this study, the results of this study may provide more information regarding the application of this group process model to child welfare MDTs.

Gitlin, Lyons, and Kolodner (1994) use concepts of social exchange theory to create their model of collaboration. Their model of collaborations has five stages: 1) assessment and goal setting, 2) determination of a collaborative fit, 3) identification of resources and reflection, 4) refinement and implementation, and 5) evaluation and feedback. In the assessment and goal setting stage team members examine their goals, the need for collaboration, and its cost-benefit ratio. Next to determine the collaborative fit, members will meet to exchange and negotiate the roles of the group and start to develop trust among each other. The third stage involves group members reassessing what resources are needed and how much effort they will need to invest to participate in the

group as well as what benefits they expect to get out of it. Refinement and implementation occur next when the group refines its work and individual members' contributions begin to differentiate. Finally, in the evaluation and feedback stage the group is working together, analyzing roles, and creating future goals.

Though the stages of collaboration may be similar to other ways of thinking about collaboration presented in the literature and this dissertation, the integration of social exchange theory of Gitlin et al. (1994) is unique. Gitlin et al. (1994) present four elements that they believe help to illustrate how social exchange theory can be seen in group work such as MDTs. In addition to concepts of exchange and negotiation, Gitlin et al. (1994) also emphasize the importance of trust and role differentiation. They argue that group members desire to maximize their output from the group while reducing the cost of participating. In order to feel comfortable to think creatively and provide constructive criticisms and counterpoints, the members must trust one another. Also, group differentiation provides members with rules, procedures, and roles needed to guide the group's work and set expectations of what every member is expected to do and not do within the team. This aids in providing all members with an environment that is conducive to completing their individual tasks. Without trust or role differentiation, MDTs lack the basic structure to engage in any type of meaningful collaboration.

Others have explored the importance of trust when it comes to a working partnership. Becerra, Lunnan, and Huemer (2008) proposed that the three elements of relational capital, transparency, and embeddedness are needed in combination to form the level of trust a partnership needs to succeed. Relational capital allows partners to work together to create advantageous results for the parties involved (Pierce, McGuire, &

Howes, 2015). Transparency in communication and accountability, a key building block of these working relationships, allows for the transfer of previously private knowledge between agencies (Schnackenberg & Tomlinson, 2014). Finally, embeddedness is the level of closeness the partners experience in their relationship (Uzzi & Lancaster, 2003). When these elements are high, so is the trust in the partnership or alliance. Although Becerra et al. (2008) used these elements to explore business relationships and alliances, Pierce et al. (2015) used them to explore the partnerships between child welfare agencies and a university training partnership. Though still not examining these factors in an MDT, parallels can be made with Pierce et al. (2015) demonstrating that concepts typically found in the business literature are also relevant in the child welfare system.

The concept of negotiation is an intriguing concept presented in Gitlin et al.'s (1994) model as it relates to child welfare MDTs. Negotiation becomes an important concept because it acknowledges that each member will possess a unique set of skills that may be valued differently by the group. Those members with a more valued skill may expect more benefits in return. As such, an MDT member who perceives their knowledge and skills to be more valued or less likely to be duplicated may expect greater influence over case planning or may want others to agree with them in times of conflict. This may impact those members on the other end of the spectrum as well. Those members who view themselves as easily replaceable may not feel they possess the power to influence the group. This can be very relevant in MDTs as professionals with varying levels of degrees and experiences often make them up.

Conflict Theory

When examining theories that can be used to gain a better understanding of how child welfare MDTs work it is important to remember the definitions of MDTs. In simple terms, MDTs consist of different members who represent unique areas of focus. These members are bound to each other because of their shared work with a family involved in the child welfare system. However, simply because team members are expected to work together to achieve a common goal does not mean that they have equal status within the team. Team members enter the team with different levels of education, degrees, experience, roles, professions, and personality traits. All of these characteristics have an impact on how others will perceive them and how much power they can wield within the team. This power differential is a potential source of conflict (Ambrose-Miller & Ashcroft, 2016; Frost & Robinson, 2007; Frost et al., 2005; Magnuson, Patten, & Looysen, 2012). Additionally, the fact that team members may have different clients, information, and mandates, may also contribute to conflict (Frost & Robinson, 2007; Frost et al., 2005). As causes of conflict and approaches to resolving conflict is the focus of this dissertation, conflict theory is an essential theory to discuss.

Conflict theory provides a way of examining conflict and inequality between people, groups, social classes, and even ideas. Although not all concepts of conflict theory are applicable to MDTs it is still critical in understanding the inner working of MDTs, especially as they attempt to address conflict between members. Conflict theories can be applied on multiple levels starting at the individual level and progressing to small groups, organizations, communities, and larger social structures (Robbins, Chatterjee, & Canda, 2011; Simon, 2016). Team members may experience individual conflict due to

intrapsychic, cognitive, or philosophical conflict at the small group level. Small group level conflict can be applied to MDT-related issues such as intergroup conflict, conflicts for leadership, conflicts due to different socializations, and conflicts due to contradictory roles or role expectations (Robbins et al., 2011). Thus, service providers may be in conflict with each other simply by their roles and the information they are given. For example, a therapist for a father who wants his children to live with him and the GAL of a child who would rather live with her mother have different roles and information because the therapist works strictly with the father while the GAL represents the children and is privy to their side of the information. Differences in socialization could also factor into conflicts if one provider is unfamiliar or comfortable with the issues impacting the family and as a result, may have unrealistic and inappropriate expectations (i.e. expecting no relapses when working in addictions or demanding better housing from those living in poverty prior to reunification despite current housing meeting all minimal state requirements).

One rendition of conflict theory that can explain conflict within a child welfare team is Realistic Conflict Theory (RCT) (Sherif, 1966). This theory argues that the nature of the goals within a group can predict the likelihood of intergroup conflict. Goals can be categorized into three separate subsets: superordinate goals which need collaboration in order to be achieved, mutually exclusive goals which likely lead to conflict, and independent goals which are separate and unrelated to the group's work and as such do not contribute to collaboration or conflict.

Examples of these goals within a child welfare team can be explained using the example of service providers working together with a married mother and father to

reunify them with their children after a removal. Perhaps the parents are engaging in couples counseling, parenting classes, and case management to find employment while the children are receiving individual therapy. All of these service providers, as well as the caseworker and GAL, are working towards the same goal of reunification. However, this is not always the case. Different circumstances such as the parents' inability to achieve treatment goals in a timely manner could change this superordinate goal to a mutually exclusive goal with the parents' providers still working with them to achieve reunification while the caseworker and GAL are beginning to prepare the children for adoption per agency and federal policy. These conflicting goals could likely cause conflict between the parents and the caseworker and GAL and there may even be some conflict between the parents' service providers and the caseworker and GAL, as well.

With this same scenario, if the case is progressing relatively smoothly, it could also be possible that the caseworker could feel pressured to close cases promptly as the supervisor believes the caseworker has a problem of remaining involved longer than case reports suggest. Thus, the caseworker has a mutually specific goal of pleasing the supervisor and avoiding criticism. However, this may go against the couples' therapist's professional ethics as there is a clear need for improvement before ending the case for fear of the parents going back to their problematic patterns of behavior despite no current major safety concerns. The therapist views their role as the couples' therapist as getting the parents to learn and practice as many positive behaviors and coping skills as they can. This role specific task is now in conflict with the caseworkers' task of ensuring the case meets court appointed deadlines and independent goal of not being reprimanded by the supervisor. In keeping with the same example, the fact that the service provider who is

providing case management for employment is going to school part-time to get her masters in social work to become a therapist would be an example of an independent goal that does not impact the goals of the team and results in neither cooperation nor conflict.

Huxham and Vangen (1996) also categorize goals in a way that is applicable to this work as they examine both individual and agency goals. They state goals can be divided into three separate types: meta-goals, individual agency goals, and individual agency representative goals. Meta-goals are the overarching objectives of the collaboration, or the MDT in this case. Individual agency goals represent the desires of the agencies that make up the collaboration. They may not necessarily be related to meta-goals, but they can influence how the agency conducts itself with the collaboration and interactions with the other agencies involved. An agency with a goal to increase its referral rate and establish a strong working relationship with public child welfare agencies might behave differently than one that already has an established relationship. Finally, the agency representative will have their own goals, which may or may not be known to the group. These goals could potentially influence collaboration if the representative had a goal of getting a positive review from outside providers they work with as part of the collaboration.

Systems Theory and Role Theory

Systems theory can also be helpful in examining MDTs because it provides a holistic approach to viewing the team. With the team as the focal system, one can view the team and its decisions as a whole. If this approach is taken, the individual team members become the subsystems that make up the team or system. Although the team itself might be involved with outside sources such as governmental laws and policies, the

individual members are also influenced by their own agencies. The fact that multiple professions by definition comprise MDTs makes this more complicated as there are different systems influencing each member. For example, some members may come from child welfare agencies, but others might come from juvenile probation. Even within the broader child welfare system there are members representing the state's child welfare system such as the family caseworker, members assigned by the court system to represent the best interest of the child such as the GAL, and yet others who belong to private agencies hired by the state to deliver services. Thus, an MDT will include governmental and nongovernmental systems as well as private, not-for-profit family service systems and court systems (both family and juvenile).

Another important concept from systems theory that is relevant to MDTs is that of dominance. In systems theory dominance occurs when groups within the system have different resources (Robbins et al., 2011). Not all team members are equal in terms of degree, experience, contact with client, or access to information. Judges involved may even favor certain team members when it comes to their decision-making process, valuing some opinions or recommendations above others. This could seep into the inner workings of the team and the interactions of its members causing an imbalance or even resentment among team members.

Several approaches have addressed how systems theories can apply to the work of an MDT. Koff, DeFriese, and Witzke (1994) used loosely coupled systems theory to explain interprofessional education though their arguments can also apply to the interprofessional collaboration found in MDTs. They stated that since each discipline brings its own philosophy, values, rules, and methodology to the group it could be

challenging to blend all the varying perspectives. As such, the different professions are loosely coupled. This loose coupling provides the mechanism for systems that might be in opposition or even conflict to function effectively.

Another perspective of how a systems theory can help explain the inner workings of MDTs is the relatively new emergence of complexity theory. Complexity theory is a set of theories about behavior in a complex system (Hood, 2012, Walby, 2007) and has been used in the health field (Ciemins, Brant, Kersten, Mullette, & Dickerson, 2016; Thompson, Fazio, Kustra, Patrick, & Stanely, 2016) as well as child welfare (Hood, 2012; Hood, 2015; Stevens & Cox, 2008; Warren-Adams & Stroud, 2013). With this approach it is believed that MDTs constitute a complex system and as such, complexity theory is needed as it focuses on patterns and relationships of complex systems (Ciemins et al., 2016; Hood 2012). Central to complexity theory are concepts of non-linearity and emergence. Non-linearity speaks to the unpredictability of working within a complex system as the combination of two actions may not always lead to the same result. This can be true when examining MDTs in child welfare as referring two families with similar needs to the same services does not always yield the same outcome. Emergence refers to the idea that behaviors of a complex system can lead to new and unexpected solutions in ways that cannot be predicted (Solomon & Risdon, 2014; Stevens & Cox, 2008). These elements speak to the fact that the interactions and outcomes of MDTs cannot be predicted according to complexity theory.

Role theory can help highlight some of the differences seen in the interactions among MDT members, especially those that result in conflict. Role theory allows one to examine MDT interactions through the lens of the roles individual members are playing

by providing an understanding of how each member was socialized into their professional role and also how they interact with others at work (Bronstein, 2003). Once again, the interprofessional nature of MDTs facilitates the requirement of varying roles. Case workers representing the state may take on different roles to help the case progress. Depending on how the case is progressing and the personality of the case worker and other professionals, the case worker might act more like a cheerleader, facilitator, or drill sergeant at any given time, to ensure that everyone is working efficiently. GALs have the role of looking out for the children's best interests. Home-based therapists take on the role of both therapist and advocate for their client. As such, therapists representing different family members may find themselves at odds with one another during a case.

Team members may have their team role, but they are also influenced by their role as a professional. Social workers' ethical role as client advocates may be enough to put the team member at odds with other members and could be a hindrance to effective collaboration. Roles also become important as one considers the needs of the family and the severity of those needs or issues. For example, if a parent is self-sufficient and relatively capable of seeking employment on their own, the role of a home-based case manager may not be as involved as that of the therapist who is helping them overcome their struggles with addiction. In this case, the roles each member play may have a direct impact on the amount of weight their concerns or opinions are given within the team.

Bronstein's (2003) Model of Interdisciplinary Collaboration

Utilizing many of the theoretical frameworks already discussed, Bronstein (2003) proposes a model for interdisciplinary collaboration based on collaboration theory from several disciplines as well as service integration, ecological system theory, and role

theory. Furthermore, this model is one of the models of interdisciplinary collaboration that is specific to social work (Jani et al., 2012). The model has been utilized and found to be applicable in multiple settings including health care settings (Jani et al., 2012), hospice teams (Parker-Oliver, Bronstein, & Kurzejeski, 2005), and in school mental health settings (Mellin et al., 2010). Although still requiring further study, this approach does suggest that the interprofessional processes found in collaboration between professionals of different disciplines should consist of what Bronstein (2003) calls five core components. These five core components are: 1) interdependence, 2) newly created professional activities, 3) flexibility, 4) collective ownership of goals, and 5) reflection on process.

Interdependence refers to the occurrence and reliance each member has on interacting with others in the collaboration in both formal and informal methods. Newly created professional activities are the collaborative acts, structures, and programs that can achieve more than if the professionals were working independently of each other outside of the collaboration. Flexibility in this model refers to deliberate role-blurring so that members take on roles not solely based on their training but also based on what is needed by the team, client, organization, or situation. Collective ownership of goals is achieved when members have a shared responsibility in the whole process of attaining the collaboration's goals. This includes being involved in the designing, defining, developing, and achieving of the goals. Reflection on the process involves members thinking about how they worked together and using feedback from each other to improve the effectiveness of the collaboration and their own working relationships (Bronstein, 2003).

Bronstein's (2003) model also encompasses influences on collaboration. As such, strictly having the five core concepts within an interdisciplinary team is not enough to ensure an effective collaboration. Collaboration also needs to be the "right recipe" of four influencing factors, all of which are very relevant and applicable to child welfare MDTs. Depending on their characteristics, these factors of: 1) professional role, 2) structural characteristics, 3) personal characteristics, and 4) history of collaboration can either help or hinder the emergence of an effective collaboration. Professional role consists of the values and ethics of the profession, an allegiance to both the agency and the profession, and respect for professional colleagues. Structural characteristics include factors like a caseload size, agency culture, professional autonomy, and factors relating to time and space. Personal characteristics pertinent to collaboration include how members perceive each other outside of their professional roles. Finally, history of collaboration refers to members' previous experience in collaborating with other disciplines (Bronstein, 2003). Thus, effective collaborations are dependent on a variety of factors that may even influence each other, further complicating an already complicated and delicate process.

An Examination of MDTs

MDTs are believed to be beneficial and essential to providing families with appropriate, timely, and effective care. They are advocated for in the literature but there has been a lack of knowledge regarding their weaknesses since they are not without flaws (Kim, Pierce, Jaggers, Imburgia, & Hall, 2016; Lalayants & Epstein, 2005). It is important to understand these flaws and develop means of addressing them because a strong interagency collaboration has been found to have an impact on the service delivery needed to reunify families and lack of collaboration has been presented as a possible

reason for poor outcomes (Chuang & Wells, 2010). Thus, when working well, MDTs can help families with complex needs successfully navigate the child welfare system and make improvements needed to result in a successful closure. However, an effective MDT is not a guarantee as many barriers and potential causes of conflict exist which can lead to damaging outcomes. It is important to understand the difference between effective and ineffective MDTs, which means that the concepts of collaboration and conflict must be explored.

MDTs in Child Welfare

As MDTs have grown in popularity (Lalayants & Epstein, 2005) so have the meetings between service providers and the families (Crampton & Natarajan, 2006). These meetings can utilize different approaches. Three prominent examples are Family Group Decision Making (FGDM), Team Decisionmaking (TDM), and Community Partnerships for Protecting Children (CPPC) (Crea & Berzin, 2009). These meetings require an investment by the agencies and the professionals involved. Although all three approaches have similarities such as a focus on the family (which is defined broadly and loosely to include who the family deems appropriate) and coordination and facilitation of meetings by trained and competent individuals, they are unique in their preparation and approach to team meetings as well as who is involved (Center for the Study of Social Policy [CSSP], 2002).

FGDM is an umbrella term with many different models. FGDM meetings are designed to develop a plan to protect and care for the children involved in the case. Family Group Conferencing (FGC) is perhaps the most common FGDM model and originated in New Zealand in the 1980s in response to the indigenous Maori people

advocating for models that took into account their culture and community. This model also corresponded to shifts in New Zealand legislation with the emphasis no longer on state responsibility for children but on the family and the community as the responsible party (Crea & Berzin, 2009). As such, the families in this approach are given more control and power regarding the planning process.

During FGDM meetings the family and their support people first hear the welfare concerns of the protective service worker. After this presentation, the family and other kin are left alone to create a plan to address all the presented concerns and place the children in an appropriate placement. This private family time is an important feature of FGDM and if the professionals and family agree to the plan, a family advocate works with the family to link them to the needed services (Crampton & Jackson, 2007). However, the professionals on the team can veto any family plan that they deem to be unsafe (Crampton & Natarajan, 2006) or place the children in foster care if there is no agreement between the family and professionals on a placement plan (Crampton & Jackson, 2007).

While FGDM meetings have the purpose of developing a plan for the safety and protection of the child, TDM meetings are designed to make an immediate decision regarding the child's placement and any needed services and supports (Crampton & Natarajan, 2006). An internal facilitator, whose role is to facilitate meetings, leads the TDM meetings. After both the family and the caseworker share relevant information, the caseworker presents the recommended plan of action. This plan is then discussed among the team and the facilitator attempts to reach a group consensus. If this is not possible, the caseworker is asked to make a decision on behalf of the agency (Crea, Crampton,

Abranson-Madden, & Usher 2008). TDM meetings require highly trained facilitators to keep the group on task and reach a consensus regarding a decision, though the child welfare agency is the ultimate deciding member, leaving them with more power on the team (Crea & Berzin, 2009). This points to a major difference between the TDM model and the FGDM model. When looking at the potential areas of conflict it would appear that professionals engaging in TDM model may be more prone to conflict as this approach requires more group consensus regarding decisions and even requires an outside facilitator to aid in the process.

In a CPPC approach, the meetings are typically run by the social worker or caseworker of record and attended by the family, community members, and formal service providers. The entire team is responsible for creating the plan of action and the family determines outcomes. However, certain pre-determined, non-negotiable items are decided on by the agency in preparation for the meeting (Crea & Berzin, 2009). Again, conflict has the potential to emerge in this approach and, unlike the TDM model, there is no highly trained, outside facilitator to help navigate any conflict that may emerge. In the CPPC approach the team is responsible for recognizing, identifying, and addressing any conflict itself. It is important to note that participants in the current study all work in a state that uses an approach to family-team meetings resembling the CPPC approach to working within MDTs.

Perspectives on MDTs

Before examining what makes an MDT effective, the MDT itself should be explored further. Child welfare MDTs have not been explored at a theoretical level to the extent that other multidisciplinary and interprofessional teams in other fields have been

studied. Drinka and Clark (2000) studied interdisciplinary health care teams and provide five primary levels of factors for such teams: 1) personal-level factors, 2) professional-level factors, 3) team-level factors, 4) organizational-level factors, and 5) maintenance factors. Personal-level factors include the norms, principles, values, education, and responsibilities of the individual professionals that make up the team. Professional-level factors involve the code of ethics, norms, practices, and guidelines that inform and shape the different professions of the various team members. Team-level factors consist of the shared norms and actions that exemplify a commitment to a unified, integrated model of practice, regardless of the personal and professional factors. Organizational-level factors focus on oversight, and resolve macro-level issues that affect practice, such as funding and policies, as well as establish the norms and standards of practice. Finally, maintenance factors focus on the actions that allow interdisciplinary efforts to become institutionalized over time.

As can be seen by these five levels of factors, the individual, as well as the larger organization and profession, can have a great influence on the operation of MDTs. These factors are applicable to MDTs in child welfare and highlight ways in which the inner workings of MDTs depend on both the micro level and macro level as teams will function differently based not only on the individuals of that team but of the organization and agencies that those individuals represent and to whom they must answer. This complexity can be particularly true in child welfare MDTs as different organizations may have different mandates when it comes to working within the child welfare system. Just as some individuals may come to teams with certain attitudes, approaches, and histories with MDTs, so do agencies and organizations. Apart from impacting how different

organizations will work with each other, these attitudes, approaches, histories, and even financial considerations from the organizational level can influence the individual workers who then enter MDTs with a certain bias. This influence can occur from trainings, supervision, and the general culture of the organization. As will be discussed, this may become problematic if negative perceptions of collaboration and mistrust are inherent aspects of the organization's culture or if leadership does not support collaboration (Mattessich & Monsey, 1992).

Another way to examine MDTs is through the lens of task group versus treatment group. Earlier the four-category organization method of Kaminer et al. (1988) was used to state that MDTs within child welfare should be considered treatment teams because they consist of treatment experts who aid in assessing, diagnosing, planning, and referring families. Crampton and Natarajan (2006) make the argument that the actual family meetings in which MDTs engage are a combination of what would be seen in a treatment group and a task group.

The difference between treatment groups and task groups is best demonstrated by the work of Toseland and Rivas (2017) who provide a clear discussion of the differences between treatment and task groups. One such area is how the group is formed and developed. Treatment groups form around common needs while task groups form around common tasks. MDT members must be aware of both the needs the family and tasks that need to be completed. Role assignment can also distinguish treatment and task groups as treatment team roles are developed through interactions, but task group roles are assigned. Many roles are assigned in MDTs such as caseworker, GAL, and therapist. Kinship care roles, if required, are not dictated to family members while some informal

roles that service providers may take on ("cheerleader" for example) are developed over time as the case progresses and a need is recognized and addressed organically.

The ways that communication occurs in MDTs also blurs the line between being strictly a treatment group or task group. This ambiguity is due to the fact that at certain times communication will be in the form of open interactions, as it is in treatment teams, but at other times, communication is more directive, as it is in task groups. Finally, when evaluating MDTs, elements of both treatment groups and task groups emerge because MDTs can be evaluated on whether tasks are accomplished such as making appropriate referrals or completing educational or therapeutic courses, but they also are evaluated on whether treatment goals have been accomplished. The mere fact that parents have completed a domestic violence class does not lead to case closure if the problematic behavior is not addressed. Using this perspective, it is clear that MDTs in child welfare have elements of both treatment and task groups. The team functions as a task group to keep the family on track but it consists of members that provide therapy and elements of treatment groups. When the team comes to together both aspects may come into play.

It is important to understand what goes into making an MDT effective. Lalayants (2013) used a qualitative study involving 91 providers and workers, including child protective workers, supervisors, team coordinators and mangers, and consultants in mental health, substance abuse, and domestic violence to examine the providers' perceived best practices of child welfare MDTs. The analysis resulted in seven themes: 1) setting the stage, 2) mandate, 3) trust and communication, 4) strong leadership, 5) building a shared identity, 6) structural supports and resources, and 7) continuous feedback and evaluation. In setting the stage the team is able to overcome any initial

resistance to teamwork and scheduling problems that are likely to occur. Having a mandate is important because it helps to ensure the commitment of team members, which is crucial. Trust and communication help to facilitate the needed respect and positive views of other professionals. Strong leadership is needed to resolve any conflict within the team and helps to combat any potential domination by one member. Structural supports and resources, such as co-location, were seen as effective but, unfortunately, are not always possible. Continuous feedback and evaluation were also viewed as beneficial (Lalayants, 2013).

The most important theme that emerged out of Lalayants's (2013) study is the concept of an MDT building a shared identity. This idea is one that others have found as well when looking at effective teams in other settings (Blakey, 2014; Green, Rockhill, Burrus, 2008). Here the team comes together and begins to learn more about each profession involved which is particularly important because MDTs are made up of many different professionals, each with their own values, perspectives, language, polices, and regulation (Glisson, 2000). Understanding each profession involved allows for members to have a more holistic view of the case, their work within it, and their other team members' work within the team as well. It also helps to reduce the power struggles and turf wars that can plague dysfunctional MDTs. MDTs that engage in this practice also have less miscommunication and conflict and are able to keep the focus on the family (Lalayants, 2013).

Lalayants's (2013) findings have possible implications when considering rural versus urban areas. As rural areas tend to have fewer service providers there is a greater chance that workers will find themselves in MDTs with professionals they have

encountered before, something their counterparts from large urban areas are far less likely to experience. If this previous working relationship was a positive one, it could lead to an efficient MDT as team building has already occurred. However reengaging with a previous MDT member can also be problematic if members had a combative relationship or had a negative experience with each other because, as will be discussed, clashing personalities (Frost et al., 2005) and mistrust (Horwath & Morrison, 2007) can be problematic to MDTs and can be sources of conflict.

Though Lalayants's (2013) study contributes greatly to the knowledge of collaboration in the child welfare system it does leave some areas unexplored. One such gap is the fact that, even though the study focused on the factors and structures that promote and impede collaboration in MDTs, there is no mention of strategies or processes to address barriers to collaboration when they occur. Lalayants (2013) does mention preemptive strategies used to address barriers such as asking interview questions about collaboration to potential hires and having team members shadow each other to gain a better insight into their responsibilities and roles within the team. These strategies, while important and seemingly effective, do not address how the team combats a breakdown in collaborations or an emergence of conflict in a timely and effective manner. The current study addresses this gap, as it focuses in on team conflict resolution. Lalayants's (2013) study also did not include any home-based therapists, leaving another gap to address. Home-based therapists are important members of child welfare MDTs and the fact that this study will focus on them addresses another gap in in the child welfare literature overall.

Interprofessional Relationships

One cannot discuss MDTs without exploring interprofessional relationships. Glennie (2007) states that there are three dominant theoretical perspectives used to examine issues within interprofessional relationships. Sociological perspectives focus on the different professional characteristics of the involved parties and their impact on the relationship. Common issues revolve around roles and power imbalances. According to Stevenson (1988), workers are socialized into their roles which in turns also shapes how they see other professions with whom they work and how they understand the nature of those interactions. This socialization is important as workers' attitudes can have either a positive or negative influence on collaboration (Drabble, 2010; Glennie, 2007). Psychodynamic perspectives involve the nature and quality of the interactions between the professionals and agencies (Glennie, 2007). Working in the child welfare system is challenging and workers cannot be expected to be immune to the pain, stress, and anxiety that may accompany assigned cases. This stress and anxiety can impact the individual workers, the organizations involved, and the working relationships between those workers and organizations (Woodhouse & Pengally, 1992). Finally, systemic thinking acknowledges the environmental factors that can shape relationships. It aims to limit compartmentalized thinking within interprofessional relationships and acknowledges that any change to the system may produce a change elsewhere. Thus, all relationships within the collaboration are important, as are the continuous feedback loops to which members belong (Glennie, 2007). All three perspectives are vital and when combined, provide an effective lens in which to view interprofessional relationships (Glennie, 2007).

If an interprofessional relationship is going to be effective the professionals involved must have specific knowledge, skills, and attitudes. Professionals should have knowledge about their own roles as well as the roles of others so they can have a clear understanding of the relationship's purpose, as well as how they can work with others and where they fit within the whole system. They must also be aware of the communication channels and have recognition of the different professional and organizational perspectives with which they will be working. Professionals must possess skills such as emotional intelligence, assertiveness, and initiative. In addition to this, they will need to be able to communicate without their own profession's jargon so that other professionals and families can have a clear understanding of what is being communicated. Finally, they must possess skills conducive to collaboration. Skills that are vital include, but are not necessarily limited to, open-mindedness and the ability to think and plan jointly with others. Attitudes that allow for an effective interprofessional relationship are empathy, respect, and appreciation for other's contributions (Glennie, 2007).

The quality of interprofessional relationships forms the basis of MDTs when it comes to how the team as a whole will function as it works towards its goals with the overall question of whether there will be collaboration or conflict. Conflict itself is not necessarily negative (Bradley, Anderson, Baur, & Klotz, 2015) but it can become problematic if it is not addressed. As will be discussed, many of the causes of conflict and the means of addressing it are elements of interprofessional relationships. Thus, positive interprofessional relationships provide the potential for an effective collaboration and lay the groundwork for resolving any conflicts that emerge.

Collaboration within MDTs

Collaboration is important to any team and has a long history of being explored when examining how teams work together. It has been defined as "a fluid process through which a group of diverse, autonomous actors (organizations or individuals) undertakes a joint initiative, solves shared problems or otherwise achieves common goals" (Abramson & Rosenthal, 1995, p. 1479). Winer and Ray (1994) highlight four different levels in which collaboration can occur. The first is an individual-to-individual level, which is collaboration between two or more team members. Next, in the individual-to-organization level a team member works with their organization to create change. In the third level of organization-to-organization, organizations collaborate with other organization. Finally, the collaborative-to-community level is when the collaboration takes its work outside of itself to the larger community. With this view, it is clear that collaboration can occur on a micro, mezzo, or macro level. However, the focus of this study is how MDTs and its members work together. As such, the individual-to-individual will be the primary focus.

Although the focus will be on the individuals, it is important to remember that team members operate in larger system than just their team. As such, organizational factors can impact how individuals function within the team and should not be overlooked. Questions regarding the agency's environment and general attitude to collaborating within MDTs are important ones to consider, as is any special training that team members might go through to prepare them to work with other professionals. Additionally, even individual factors such as attitudes and beliefs towards collaboration can impact collaboration. Drabble (2010) found that negative perceptions of collaboration

acts as a significant barrier. Cultural differences and status differences between the professional groups can also inhibit collaboration (Easen, Atkins, & Dyson, 2000). In addition to professional culture, each organization that employs these professionals will have its own culture and attitude towards collaboration which can either positively or negatively influence a team member's level of collaboration (Ambrose-Miller & Ashcroft, 2016). Due to the potential impact of these factors, this study will also explore questions regarding agency training and culture relating to collaboration as well as the individual's perceptions regarding collaboration. As will be described in the following section, barriers to collaboration can be strong enough at times to go beyond preventing collaboration and can lead to conflict.

The ways collaborations are approached and executed can also vary. Horwath and Morrison (2007) reviewed the literature and suggest that collaboration can occur in a range consisting of five different levels. Communication is the simplest form of collaboration and involves individuals from different disciplines talking together. Cooperation, the next level, occurs when low-key joint working occurs on a case-by-case basis. Coordination involves more formalized joint working but there are no sanctions for non-compliance. Fourth, coalitions are joint structures sacrificing some autonomy. Finally, the highest level of collaboration is integration where organizations are merged to create a new joint identity.

As agencies or teams move across this continuum, agreements become more formal, there is joint responsibility, sharing of resources, and joint decision-making. However, how does one distinguish among these levels of collaboration? Marrett (1971) provides four dimensions in order to do just that and Ovretveit (1996) provides the same

examination while focusing specifically on MDTs. The first distinguishing dimension is formalization, which describes the agreement, and/or contracts regarding how much autonomy each party has or has relinquished in the partnership. Intensity refers to the range of activities and resources involved in the collaboration. The reciprocity dimension takes into account power differentials between partners. The last dimension, standardization, refers to the degree to which the work of the collaboration is clearly defined and standardized.

D'Amour et al. (2005) examined the literature regarding core concepts and theoretical frameworks of interprofessional collaboration. They found two constant and key elements to collaboration. One is that the created collective action is done so to address the complexity of clients' needs. The other key element is that, in addition to members respecting and trusting each other, the team functions in a way that integrates each member's perspective. D'Amour et al. (2005) also found four major concepts to interprofessional collaboration: 1) sharing, 2) partnership, 3) interdependence, and 4) power. For an effective collaboration there must be an element of sharing. This sharing can refer to decision-making, information, values, and responsibilities. The researchers found that a collaborative partnership can be characterized by an authentic and constructive, collegial-like relationship with open and honest conversation as well as mutual trust and respect. Interdependence means that members are dependent on each other and this dependence arises from the common desire to address the client's presenting issues. Finally, power is to be shared and based on the knowledge and skill each member possesses rather than their title.

Horwath and Morrison (2007) also provide what they term to be the ingredients of collaboration as they examine and synthesize the literature regarding interagency collaborations, though these ingredients can easily apply to MDTs. First, there are predisposing factors, such as history between the agencies, existing informal networks, and the cohesion of the individual agencies, that can potentially impact how the team may work together. The next important element of collaboration is a mandate, which provides a shared need to collaborate allowing for shared goals and strategic planning. Membership and leadership are also important as members need to work well with each other, trust one another, share power and responsibility equally, and have a general understanding and appreciation of each other's roles. Leadership is crucial because it fosters these elements and promotes collaboration. The final ingredients are machinery and process. Machinery refers to the structure of the collaboration, which includes accountability, formal control, and resources. Process involves the interactions and relationships of the collaboration. As such, elements of trust, communication, and values make up this final ingredient.

Collaboration is important for any team and exploring how collaboration comes to be is a crucial exercise. It is also important to remember that within a child welfare team, the stakes are high, and the end result can allow a family to reunify or terminate parental rights. Aunos and Pacheco (2013) explored child welfare service providers' perspectives on collaboration involving child welfare agencies and workers of a rehabilitation center for parents with intellectual disabilities. They were able to identify several key factors to collaboration that included strong communication and a successful team with shared goals, mutual control, and a joint decision-making process. Perhaps more importantly,

they also found that the more elements of collaboration within the case, the more likely an out of court decision was reached resulting in the child either remaining or reunifying the family. Drinka and Clark (2000) also found that improved collaboration produced the desired results of both the team and the patient in healthcare teams. Additionally, interagency collaboration has a positive impact on the behavioral health services needed by children in the child welfare system (Chuang & Wells, 2010). Collaboration also can lead to reduced fragmentation and duplication when it comes to resources and services which aids in helping to reduce the length of services and the risk of re-entry (USDHHS, 2019).

Spath, Werrbach, and Pine (2008) studied a partnership between two state child welfare agencies and a private child welfare agency with the goal of reunifying families after the children had been removed and placed in foster care. Utilizing a mixed-methods approach, the researchers had 41 key informants participate in interviews and questionnaires. From this work three key factors to collaboration among agencies were identified: 1) strong communication, 2) strong leadership, and 3) successful teaming. Strong communication allows the team to be on the same page in terms of services needed and the progression of the case by consistently sharing information. Teams with a strong leader have someone who will be able to problem-solve when needed. This leader must be one who is also able to accept and provide constructive criticism. Strong leadership is also needed to navigate the balance of the child welfare system's delicate purpose of keeping children safe while also aiming to preserve families. Finally, successful teaming provides the team with a shared vision and goals, mutual respect for

all members, the desire to learn from each other and about each other, and the ability and willingness to problem-solve together.

Strong communication, strong leadership, and successful teaming are only some of the concepts found in collaboration studies involving social work agencies. Knowledge, role clarity, and resources were critical factors in a study of child protection and adult mental health collaborative efforts (Darlington, Feeney, & Rixon, 2005). Individual skills needed for interdisciplinary collaboration efforts are analytical skills, such as problem solving, priority setting, critical thinking, and interpersonal skills such as communication skills and conflict management (Korazim-Korosy et al., 2007). Finally, the concept of mutuality, which Wimpfheimer, Bloom, and Kramer (1991) define as "the recognition of a common problem and the acceptance of cooperation as a potential resolution of the problem by the prospective collaborators" (p. 91), has been shown to be an important aspect in their work regarding inter-agency collaboration as well as others within the same field (Aunos & Pacheco, 2013; Spath et al., 2008).

Interprofessional collaboration can be difficult and can even be viewed as burdensome by those engaging in it (Drabble, 2007). It can take some time to develop the require skills to collaborate effectively so it is not surprising that a lack of interdisciplinary experience can be a challenge to this work (Jani, Trice, & Wiseman, 2012). Collaboration within MDTs requires intentional efforts of service providers at all time. Barriers to collaboration include issues with leadership, lack of clear roles, and different philosophies, practices, and goals of team members (Lalayants, 2013). Lack of communication (Ambrose-Miller & Ashcroft, 2016; Lalayants, 2013; Lewandowski, & GlenMaye, 2002), scheduling difficulties (Easen et al., 2000; Kim et al., 2016; Lalayants,

2013), and lack of respect (Lewandowski, & GlenMaye, 2002) are also key barriers to collaboration. Salhani and Charles's (2007) examination of residential child welfare interprofessional teams utilizing interviews and observations highlight other barriers such as issues regarding power differentials, both real and perceived, as well as undesirable attitudes that team members bring to the team. Issues of mistrust between team members can be problematic as well (Horwath & Morrison, 2007) as can be issues related to territory and power (Rose, 2011).

Conflict within MDTs

Conflict among team members of an MDT is an extremely important concept to understand and warrants the attention of researchers, practitioners, and administrators. Conflict within an MDT can occur during team meetings (family team meetings or service provider meetings) as well as via email, telephone, or individual interactions among team members. Due to the various professionals with distinct roles, perspectives, clients, and at times information, there are many different possibilities where conflict could emerge among different members or different combinations of members.

An increasing volume of literature addresses conflict within teams/groups in the workplace. Although engaging in conflict is often unpleasant and unwanted by those involved, some researchers have argued that conflict can be beneficial to the overall production of a team. Some meta-analyses (De Dreu & Weingart, 2003; de Wit et al., 2012; O'Neill, Allen, & Hastings, 2013) provide evidence that relationship between team members, task complexity, and task importance may moderate conflict.

Bradley et al. (2015) through their meta-analysis, suggest that task conflict (discussed in more detail in the upcoming section), though often associated with negative

outcomes for team performance, can in fact have a positive impact on performance if certain conditions are met such as teams working on sufficiently complex tasks, teams being able to appropriately process information, and the conflict being expressed appropriately at the time of its conception. Bradley et al. (2015) present additional conditions that can lead to positive outcomes emerging from conflict including the timing of the conflict and factors relating to leadership, communication, and conflict management found within in the team.

Coser's (1956) work exploring the function of social conflict through Georg Simmel's work on conflict provides another way of seeing conflict. Though originally writing about social conflict in society, many of Simmel's arguments can be applied to groups and MDTs specifically. One proposition made about conflict that is relevant for MDTs is that conflict can act as a safety valve of sorts, allowing members to clear the air and prevent too much hostility from building up within the team. Another proposition is that conflict has a specific impact and function to group structures in that it can help bring the group together and re-establish unity. When considering MDTs tasked with addressing the needs of the family, conflicts can help bring the members together and refocus them, assuming they are able to work through the conflict.

Jehn (1995) used 105 work groups and management teams to study conflict and also found some positive aspects. Conflict emerging within a team can provide the benefit of causing team members to engage in more in-depth conversations about concerns and/or strengths of potential actions. This allows all team members to have a better understanding of the issue the team is facing as well as each other's views on it.

This process can result in a higher potential to reach a well-informed agreement (Jehn, 1995).

Though conflict clearly has some potential benefits, when not addressed effectively it can cause mistrust or a communication breakdown between team members. This can shift the focus away from the family and have a negative impact on the needed services provided to a family as it attempts to reunify. Here Coser (1956) presents more propositions of conflict that may be either beneficial or problematic when occurring in MDTs. The fact that conflict can create associations and coalitions is one such example. Here a situation may arise where professionals have differing views on how the case should progress and may team up to present their side. This has potential to be beneficial if both sides are able to communicate respectfully and openly, however, it could be counterproductive if it turns into a consistent "us versus them" mentality.

Types of conflict. There are multiple views of how to categorize the types of conflict team members encounter as they work together. One approach assumes that conflict with a team like an MDT can be differentiated into two types: 1) task conflict and 2) relationship conflict (Jehn, 1995). Task conflict occurs when team members have opposing opinions toward viewpoints, ideas, and thoughts (Jehn, 1995). In terms of a child welfare MDT, this could include opinions on services needed, the level of visitation that is appropriate, and case closures recommendations. When examining task conflict, it is important to remember the task the team is assigned. In child welfare MDTs that task is deciding whether or family should be reunited, or parental rights should be terminated. The fact that conflict emerges should not be surprising considering the important, life-altering, and high stakes tasks that MDTs are expected to achieve. Relationship conflict

involves interpersonal incompatibilities, which can result in annoyance, tension, and hostility (Jehn, 1995). Relationship conflict often leads to negative responses which can have a harmful effect on the team's functioning while task conflict can be a catalyst to a better working team with more unified goals as members are presented with the opportunity to express and clarify opinions and concepts (Jehn, 1995). However, task conflict has been shown to be associated with relationship conflict in several systematic reviews (De Dreu & Weingart, 2003; Simons & Peterson 2000). Simons and Peterson (2000) provide two possible explanations for task conflict leading to relationship conflict. One is due to misinterpretation, as differences in opinions may be wrongfully viewed as a personal attack causing a dispute in the relationship. This conflict may occur if a team member expresses or advocates for their opinion in a way that is deemed to be so inappropriate that other team members are left feeling humiliated or hurt which damages the relationship.

More recently the idea of a third type of conflict, process conflict, has been added to Jehn's (1995) original two type model (de Wit et al., 2012). Process conflicts are disagreements about the logistic issues. These conflicts may be as simple as when to schedule meetings but can also be complex such as the delegation of responsibilities amongst team members or how services will be carried out (de Wit et al., 2012). For child welfare MDTs this may present as conflict over which team member should be responsible for informing clients of bad news or who should search for needed services for clients. Complicating matters is the fact that MDTs are made of different professionals representing different agency, all of which have their own policies and

procedures which may not coincide with each other. Therefore, team members may be forced into process conflict simply by following their own agency's procedures.

As a result of their examination of conflict resolution studies, Edmund (2010) provides another way to categorize conflict. Here group conflict is divided into three different categories each with varying degrees of intensity. Event-based conflict is the least intense and is short term without deep roots. This type of conflict is based on team members having different interpretations of specific events, needs, or tactics. Event-based conflict essentially results from a misunderstanding and reveals the different perceptions of team members, which are rooted, in their different interests. In the case of MDTs, while all team members have the ultimate goal of a safe reunification for the family, many times team members will have different clients as they could work solely with a parent or the children. As a result, professionals will often have slightly different interpretations of events as they may view it through the lens of their client or come to those interpretations based on information from their client, which could be biased. These different interpretations are prime reasons for event-based conflict to occur. Most of the time, event-based conflict, like task conflict, can be easily addressed. However, problems may arise when teams avoid addressing event-based conflict, which can lead to a more challenging and disruptive form of conflict.

Communicative-affect conflict is the second degree of conflict that Edmund (2010) presents. This degree of conflict has deeper roots than event-based conflict and results from a longer shared group history, differing emotions, or different goals, which team members must process together. Communicative-affect conflict results because the issues are meaningful enough that they have a significant impact on the persons involved

or the whole group but miscommunication and/or a contemptible affect has developed during the conflict period. Past disputes, as well as power struggles, are often brought up again during this conflict, which may resort to "dirty fighting." Communicative-affect conflict can be resolved with authentic communication to reform members' understandings of the situation. This requires a level of communication skills, trust, and a willingness to place the group's interest ahead of one's own. Unfortunately, not all groups or group members are equipped with these traits.

The third and final degree of conflict presented by Edmund (2010) is identity-based conflict, which occurs when either the group identity or an individual group member's identity is threatened. This type of conflict can have a transformative effect with either positive or negative results and, according to Northrup (1989), unfolds in four sequential stages the build off of each other. First there is a threat to individual or group identity. Next there is a distortion of perception where other group members are now perceived as the enemy. In the third step, conflict tactics and dynamics become more rigid. If the conflict reaches the final stage, the group will break up into smaller, opposing sides and there will be an agreement among group members to maintain the conflict in order to maintain identity. If a group is going to address identity-based conflict, it is important that it understands and accept that fact that conflict can be constructive.

In reviewing the types of conflict, whether categorized using two or three levels, Northrup (1989) provides useful observations for any level. First, conflict evolves over time and is not static. Also, group conflict can involve multiple levels of conflict simultaneously as when task conflict is left unresolved, it runs the risks of evolving into relationship conflict. The same is true for event-based conflict as it can turn into

communicative-affect conflict. The danger here is that resolving the conflict becomes more complicated when this occurs as the conflict is now more embedded within the team and can do more damage. Group conflict also is composed of subjective and objective components, both of which need to be addressed when seeking a resolution. Finally, issues of power can significantly impact how the conflict is played out and progressed (Northrup, 1989).

Causes of conflict. MDTs consists of multiple professionals that each join the team with slightly different professional philosophies, ethics, language, and practices. They have gone through a professional socialization and have emerged with different professional identities that may not always align with other professions represented within the team. Specifically related to social workers which represent many of the home-based therapists, Oliver (2013) proposes that a social work identity is often contested within many of the interprofessional settings in which social workers can now find themselves. Although MDTs within child welfare might be more closely aligned with social work than other interprofessional settings, having multiple professional identities can still be problematic at times due to differences in perspectives, ethics, and values which help to shape how each team member approaches their work for the team, the work of the team, and the even team itself.

Logistical barriers such as scheduling meetings can make working within an MDT challenging (Kim et al., 2016). Team members often have busy schedules and work for separate agencies with different policies. In addition to this, individual team members often have different clients within the family each with their own unique goals and even varying levels of information regarding pertinent events of the case. With these

differences and the high stakes of deciding a family's fate, conflicts are to be expected in group work.

Frost et al. (2005) used a three-phase qualitative, multimethod study consisting of examining documents from MDTs and observing team meetings, conducting individual interviews based on the findings from the documents and team meetings, and engaging MDT members in focus groups based on case vignettes. Their findings highlight different causes of conflicts that arise within an MDT. These causes are due to team members having differing core values, models, and not sharing a common language or terminology. Power or status differences within a team can also be problematic (Frost et al., 2005; Kim et al., 2016; Magnuson, Patten, & Looysen, 2012), especially if that team member uses this imbalance in power to control aspects of the team like case planning and management (Kim et al., 2016). Frost et al.'s (2005) study was based in the United Kingdom as it transitioned to a new approach in child welfare. Though its findings are consistent with other literature, it did have a narrow focus and sample and again its focus is on the causes of conflict without investigating how teams work through the resulting conflict.

Brown et al. (2011) took an in-depth look at conflict among primary healthcare teams. Though the researchers used primary health care teams in Canada, the findings are relevant to child welfare MDTs found in America. From this phenomenological study, three sources of team conflict emerged: role boundary issues, lack of accountability, and scope of practice. In this study a lack of understanding contributed to both the role boundary issues and issues related to scope of practice. Ambrose-Miller and Ashcroft (2016) also conducted a study in Canada but used social educators, practitioners, and

students and by using focus groups, they too found that lack of clear roles could be a barrier to collaboration. Frost and Robinson (2007) also found that a lack of understanding of each other's roles was also a cause of conflict within child welfare MDTs.

Conflict can also arise from team members having clashing personalities (Frost et al., 2005), different information about the case, different objectives (Frost & Robinson, 2007; Frost et al., 2005), or different opinions when it comes to creating goals and referring services (Kim et al., 2016). Different information and objectives for each service provider can cause disagreements about when certain providers should close cases (Frost et al., 2005). Having different primary clients and thus a different focus than other team members can also be a barrier to team members collaborating fully and effectively (Young & Gardner, 2002). Having different clients may also create a different underlying issue of some team members being focused solely on their individual client whether it is a child or parent while others might be more focused on the family. This difference in focus could lead to conflicting outlooks, goals, and solutions. This has potential implications for child welfare MDTs as some team members may work exclusively with a child while others may work with the parent(s). In other cases, there may also be two parents that are separated or divorced who have conflicting goals when it comes to the outcome of the case. They may both be vying for full custody of the child, which could put team members at odds with each other.

Conflict may also occur due to different views of the client (Frost et al., 2005). In Smith's (2008) study, case workers admitted to seeing the parent as someone who has wronged their child and needs to be punished. They even sometimes went as far as to

think that a parent needed to have their love and dedication to that child tested. These caseworkers used treatment plans overloaded with services to punish or test parents (Smith, 2008). This view is inconsistent with the ethics and values of social workers (NASW, 2008) and could lead to tensions among team members if a team member suspected or learned a caseworker was engaging in this practice. These practices may cause conflict to arise between the caseworker and a home-based therapist who, in addition to providing therapy to the parent, may also take on the role of advocate and stand up for a client if they see him or her being treated unfairly. This conflict would be intensified depending on how each other views the client.

Addressing conflict. Conflict within MDTs can take the focus away from their ultimate goals. As has been illustrated above, much is known about why these conflicts arise, but little is known about how the team members resolve them once they happen. In terms of child welfare MDTs, the goal is to ensure children have a safe and permanent place to live and grow, ideally with their family (INDCS, 2014; USDHHS, 2019). Conflicts can lead to a breakdown in collaboration and communication, which appear to be vital to a successful MDT (Johnson, 2013). Furthermore, once disagreements among team members emerge, they can lead to the formation of different alliances based on where team members fall on the issue (Northrup, 1989). Once this occurs, a dangerous process of inclusion and exclusion can occur between the groups with each one developing an inner core that is critical of the other (Hood, 2015).

Children and families deserve effective treatment, especially when there is the potential for parental rights to be terminated. For social workers, providing effective treatment is not only good practice but also a core value of the profession as part of the

NASW *Code of Ethics* (2008). Unresolved conflict among services members is counterproductive to this value and thus needs to be addressed. However, how service providers go about resolving any potential conflict has not garnered the attention it should in the child welfare research. This lack of attention is unfortunate as conflict resolution strategies are an important aspect of providing services to families in need and as such, is a vital aspect of the child welfare system and its service delivery.

Northrup (1989) examined how group conflict emerges and then how the group responds. Based on this work it is assumed that parties handle conflict and the process of resolving it in a rational and logical manner. To do this, clarification of the misperception which resulted in the conflict, needs to be the central method of the resolution process. However, the assumption that team members desire a peaceful relationship with all team members and a peaceful resolution to the conflict is not always the case as some members are not always willing to meet and process conflict to reach a resolution. These principles of conflict resolution can be applied in many settings, with MDTs being just one of them.

As one examines different ways conflicts within MDTs can be addressed, it is important to understand that at times conflict is not addressed at all. The research team of Brown et al., (2011) found four barriers to conflict resolution as they examined primary healthcare teams: time and workload, people with less power, lack of recognition or motivation to address conflict, and avoidance of addressing conflict due to a fear of causing more emotional distress among team members. Lack of time and a busy schedule make it difficult for teams to address any conflict that may occur, however when left unresolved conflict can intensify and spill over into other areas. Issues related to time

have been found to be problematic in child welfare MDTs, as well (Kim et al., 2016). An imbalance of power, which has also been discussed as a cause of conflict (Ambrose-Miller & Ashcroft, 2016; Frost et al., 2005; Magnuson et al., 2012), is now also seen as a barrier as those with less power can feel intimidated, resulting in their silence when conflict occurs. Finally, the last two barriers result from some forms of avoidance either through not being able to see the conflict or not wanting to address it whether due to a general discomfort with conflict or a desire to protect other team members and spare their feelings (Brown et al., 2011).

Conflict among teams can be examined using several approaches. Brown et al. (2011) present solutions to address conflict within primary healthcare teams that includes both team approaches and individual approaches. Thus, the team as a whole or its individual members can be the catalyst for resolving the conflict. Regardless of who is spearheading the conflict resolution, helpful approaches involve open and direct communication, a willingness to find a solution, and showing respect and humility.

If conflict is going to be addressed it is often done utilizing some form of a conflict management style, which, according to Thomas (1976) (as cited in Montes, Rodriguez, & Serrano, 2012), can be thought of as observable behaviors guided by a general and consistent orientation toward both the other person and the conflict issues. For over fifty years, this general orientation has been presented in a variety of styles in multiple areas of studies. Follet (1942) (as cited in Montes et al., 2012) presented and described five conflict-handling styles: domination, compromise, integration, avoidance, and suppression. Deutsch (1949) (as cited in Montes et al., 2012) attempted to simplify matters by presenting a dichotomous approach of cooperation or competition.

Blake and Mouton (1964) present another model consisting of a five-mode system of classifying conflict management styles by using forcing, withdrawing, smoothing, compromising, and problem-solving modes. Blake and Mouton (1964) also conceptualized the Managerial Grid, which was a way of comprehending why a certain conflict management style was chosen by an individual. Essentially, it states that a manager will pick a specific mode based on where they fall in their level of concern regarding production and people. As such, a manager with a high concern for production and a low concern for people will pick a mode different than that of a person who values the people over the production.

The Managerial Grid (Blake & Mouton, 1964) has been reinterpreted several times by Blake and Mouton as well as others. In their study regarding conflict management styles, Montes et al. (2012) used the conceptualized conflictual styles based on the work of Rahim and Bonoma (1979). This approach proclaims the deciding factors not as production versus people, but as self-versus-others, meaning decisions are made based on either concerns for one's own self-interest or to satisfy the needs and concerns of others. According to Montes et al. (2012), Rahim and Bonoma's (1979) revision is the most popular partly due to the empirical evidence supporting it (e.g. Rahim and Magner, 1995).

The first style that Rahim and Bonoma (1979) conceptualize; integrating (high concern for self and others) is made up of cooperative behaviors aimed at obtaining mutually favored solutions. Within this approach, people focus on shared goals and work through conflict with creativity, flexibility, and an open approach to communication and information sharing. The second style is obliging (low concern for self and high concern

for others). Those utilizing this style can be characterized as failing to engage in a complete evaluation or alternatives to the conflict in favor of giving in to one side. The third style is dominating (high concern for self and low concern for others) which utilizes a win-lose approach where conflicting parties are required to use a confrontational approach so that one side forces the other to concede. Individuals utilizing this approach will often use directive communication, persistently argue for their side, and attempt to take control of the interaction. Avoiding (low concern for self and others) is the fourth style in this conceptualization and consists of behaviors designed to limit addressing any conflict either through ignoring it or changing the conversation. Finally, compromising is in the middle of the dimensions across the concern for self and the concern for others. Tactics used in this approach include appealing to fairness, offering quick, short term solutions, suggesting trade-offs, and attempting to maximize wins and minimizes loses. As this is a middle ground approach, there is an interest in finding a mutually acceptable solution to the conflict but without as strong of a push as found in the integrating style. When considering MDTs and their need to use multiple professionals to make the most informed decision possible for families, it could be argued that different professionals may use different approaches based on their own personality, background, and role with the team. However, as this study attempts to gain knowledge and build a theory from the ground up, the researcher will explore how home-based therapist approach conflict and can compare it to these approaches.

Though Montes et al. (2012) use conflict management styles that operate under the belief that decisions regarding which style to choose is guided by the person's concern for self and concerns for others, they also explored another possible deciding

factor. They examine how a person's affect may contribute to their conflict management style, concluding that those with more positive moods and feelings were found to have a stronger preference for more cooperative approaches to conflict. This demonstrates that personality and affect can also play a role in conflict resolution and is worth examining.

Gaps in the Literature

There is a developing area of literature for conflict and collaboration within MDTs. This emerging field is not without its gaps though. While factors of collaboration are well documented (D'Amour et al., 2005; Horwath & Morrison, 2007; Spath et al., 2008), they have not focused specifically on home-based therapists and their perceptions of collaboration and roles in establishing and maintaining it. These leaves gaps around the experiences and perceptions of home-based therapists when it comes to collaboration. In the same vein, conflict within child welfare MDTs also has been explored but mostly by studying the causes (Frost & Robinson, 2007; Frost et al., 2005; Magnuson et al., 2012; Young & Gardner, 2002) or prevention methods (Lalayants, 2013). This leaves the area of conflict resolution understudied and largely ignored in the child welfare literature. Previous studies have explored what factors can cause conflict (Frost & Robinson, 2007; Frost et al., 2005; Magnuson et al., 2012; Young & Gardner, 2002) and also how to prevent it (Lalayants, 2013), but now how a team addresses it once it emerges or specially how home-based therapists navigate this process. It is because of these gaps in the literature that the researcher developed his research questions and conducted this study.

Chapter III: Research Methods

In reviewing the literature, it is apparent that MDTs are widely used in the child welfare system and are beginning to be examined as an important element of providing services to families in need. Although elements of what makes an effective team, as well as barriers teams face, appear more frequently now in the literature, how team members overcome conflict is lacking. Conflict can obviously arise within MDTs and can be problematic without properly being addressed. Conflict resolution is examined in other professions in areas relating to healthcare, business, and sociology fields but it is not clear if these same approaches occur within child welfare teams. Specifically, how child welfare service providers address conflict with their fellow team members is a needed area of study. This study will add to the literature of what causes such conflicts but will also move the scholarship into how professionals can effectively address these conflicts when they emerge by focusing on the process of conflict resolution.

A proposed model of conflict resolution could be tested and if shown to be accurate and applicable, could be used to train and educate child welfare professionals to reduce the negative effects of conflict and improve the time and manner in which conflicts are addressed and resolved. In studying conflict, one cannot ignore its counterpoint, collaboration. Factors that both promote and impede collaboration will be foci of this study. As such this study attempts to address the following two research questions:

1) What do home-based therapists perceive to be important facilitators and barriers to collaboration for child welfare MDTs?

2) How do child welfare home-based therapists resolve conflict once it emerges within the MDT?

Qualitative Methods

The research methods of a study should be and need to be driven by the research question(s). In adhering to this practice, researchers use the question to guide whether quantitative methods or qualitative methods are utilized. Qualitative methods are best suited for studies with a goal of uncovering a deeper level of understanding of perceptions, attitudes, and processes (Glesne, 2010). Exploring the inner workings of practice is also well suited for qualitative methods (Padgett, 2008). Other deciding factors for undertaking qualitative studies include amount and complexity of information already known about the topic as exploring previously understudied, complex topics lends itself to a qualitative approach (Creswell, 2014; Padgett, 2008). Qualitative methods are appropriate for this study because the research questions explore processes of conflict resolution within child welfare MDTs. In addition, the researcher desires to get an insider's perspective.

Researchers have multiple approaches from which to choose when considering qualitative methods. Just as choosing to use qualitative methods is driven by the research question, selection of a qualitative approach should also be driven by the research question. Factors such as the manner in which questions are asked and the data are coded can be impacted by the approach selected. Furthermore, certain approaches are better suited for certain research questions. As this research study ultimately aims to get at a better understanding of the process of resolving conflict, grounded theory is the logical approach.

Grounded Theory

Grounded theory is a well-known approach to qualitative research and has increased in popularity since its inception in 1967 (Glaser & Strauss, 1967). Influenced heavily by symbolic interactionism and ethnographic sociology it has evolved over time (Padgett, 2008). Grounded theory has survived a falling out between Glaser and Strauss resulting in the two founders separating their work. Both Glaser, working alone, and Strauss, who would team up with Corbin, continued to work and publish on grounded theory (Padgett, 2008). Recently a new wave of grounded theory has emerged, thus creating different versions adapted to fit within constructivism (Charmaz, 2014) and postmodernism by (Clarke, 2005). Rupsiene and Pranskuniene (2010) examined grounded theory's colorful history and point out that Glaser does not accept other iterations as true to grounded theory, but they argue that most epistemological approaches should accept the different variations.

Despite these variations, studies using grounded theory all entail the use of inductive coding of the data and the weaving in of theoretical ideas and concepts while not allowing them to constrain or drive the findings that are emerging from the data (Padgett, 2008). The goal of grounded theory is to use the emerged data to construct theory without forcing any preconceived ideas or theories onto the data (Charmaz, 2014). Padgett (2008) best explains the value of grounded theory as research method that "has made the pursuit of midrange theories a respectable, even desirable outcome of qualitative research" (p. 32).

The current qualitative study utilized a grounded theory approach and methods. More specifically, this study used the grounded theory as elucidated by Charmaz (2014),

who utilizes a version of grounded theory that is influenced by constructivism. In this approach, grounded theory methods "consist of systematic, yet flexible guidelines for collecting and analyzing qualitative data to construct theories from the data themselves" (Charmaz, 2014, p. 1). This allows researchers to construct theories that are "grounded" in the data. That is, this method used the actual words of home-based workers as data, which were analyzed. In fact, this method goes beyond simply description analysis, as thematic analysis is the goal. A true grounded theory should result in a theory, so while providing rich descriptions and important is just one step towards the overarching goal of constructing a theory. The role of the researcher is also stressed and there is acknowledgement that there will a certain level of subjectivity that objectivist grounded theory does not hold to be true. It also favors new categories over preconceived ideas and existing theories as this allows ideas, concepts, and theories to truly emerge from the data as opposed to applying the data to a preconceived or existing theory (Charmaz, 2014).

Charmaz's (2014) constructivist grounded theory differs from what she calls objectivist grounded theory, which takes a more positivist approach. As Charmaz's (2014) approach is rooted in constructivism it is important to highlight some foundational assumptions that shape this approach. One assumption is the existence of multiple realities. The role of the researcher is also stressed and there is acknowledgement that there will a certain level of subjectively which tends to be under-acknowledged in objectivist grounded theory. This impacts how each approach views data analysis. Although those subscribing to an objectivist approach will discuss the discovery of data and conceptualization emerging from data analysis, a constructivist grounded theorist will state that data is constructed through their interaction with it and they help to

construct categories. Furthermore, while objectivists assume neutrality, passivity, and authority of the observer, constructivists assume that the observer's values, priorities, and actions affect their views. This difference also impacts data analysis as a practitioner of constructivist grounded theory acknowledges that there is subjectivity throughout the data analysis process and also seeks and represents participants' views as an integral part of data analysis ensuring that participants subjective experiences become a focus of the analysis. This view is opposed to a more objectivist approach, which sees data analysis as an objective process and places priority on the researcher's analytical categories and voice (Charmaz, 2014).

Grounded theory is unique in several ways. One is ways in which the different approaches view a priori knowledge and previous theories. Although in its original form, the literature review, it was argued, should be avoided until after the data were analyzed (Glaser & Strauss, 1967). However, this approach is not always followed or practical (Charmaz, 2014). Charmaz (2014) has a less rigid view of this approach and states, "I have argued that earlier theoretical concepts may provide starting points for looking *at* your data but they do not offer automatic codes *for* analyzing these data" (p. 159). Here it is clear that a priori knowledge does not need to be ignored but it should be used with caution and with care so as to not overtake the data itself and becoming the driving force of the data analysis.

Specifically, when it comes to writing a literature review, Charmaz (2014) accepts the fact that it will have to come before conducting research in different cases and challenges researchers to use it to their advantage when this occurs. Literature reviews can be used as a means to set the stage for what the researcher does in future chapters or

sections and as a way to challenge researchers to clarify their own ideas and show the reader how and where their work fits into the existing literature in addition to how it will expand existing concepts or address gaps in the literature (Charmaz, 2014). This reasoning supports the case for this study's literature review, as well as a review of relevant theories, which were both required and completed before data collection even occurred. Acknowledging this is important. This researcher discloses that despite a priori knowledge, a process of engagement of various practices (such as writing memos that will be discussed in more detail in a later section) ensures that the data analysis that follows is not overly influenced by this a priori knowledge.

A similar approach can be taken to developing theoretical frameworks in grounded theory. Here Charmaz (2014) acknowledges that this can be difficult but theoretical frameworks can still be written in inductive grounded theory studies and serve a strong purpose. They can provide ways to show the reader how researchers want them to think about their analysis. They also serve as anchors for readers and give them the opportunity to see how the study will refine, challenge, or supersede existing concepts. Again, Charmaz (2014) challenges those engaging in grounded theory to write well-constructed theoretical frameworks that clarify the researcher's conceptual logic and direction, acknowledge prior theoretical works, position the new grounded theory in relation to these theories, and explain the significance of original concepts that emerged from the study.

Another way grounded theory is unique is the ability of the researcher to engage in data analysis and data collection simultaneously with the analysis informing the ongoing collection. The constant comparison method is used to raise the level of

abstraction of a researcher's analyses by engaging in comparison within each stage of analysis. Thus, a researcher will compare data with data, data with code, code with code, code with category, category with category, and category with concept (Charmaz, 2014).

The goal of constructivist grounded theory is to obtain abstract understanding of the studied concept with the researcher viewing their analyses as located in time, place, and the situation of the research (Charmaz, 2014). This method, then, is an appropriate approach to gain a deeper understanding about ways in which home-based therapists resolve conflict within MDTs. By engaging in grounded theory methods, this researcher wanted to and was able to develop a theory to describe the process as to how this occurs. This process goes beyond describing the experiences or causes of conflict within MDTs and illuminates the process and stages that occur when home-based therapists are able to resolve the conflict with MDTs.

Sampling in Grounded Theory

Determining how many interviews to conduct in a grounded theory study is a difficult task and one that has a wide range of answers when looking at different studies. Charmaz (2014) states that the question of sample size has three assumptions, all of which are problematic. The first assumption is that there is a number that can be known. and second, that researchers will be able to state this number. Finally, it also assumes that the experts would then agree on that specific number. When engaging in qualitative studies, especially when the goal is to construct a new theory, the researcher will most likely not know exactly what they need to know until some analysis begins. This makes knowing an exact sample size impossible to know prior to conducting the research.

Charmaz (2014) does provide guidelines to assist researchers in knowing how large of a sample to use. These suggestions assume that the researcher is seeking to achieve excellence rather than adequacy and will help to increase professional credibility of the study. She recommends increasing sample sizes when the researcher is: researching controversial topics, constructing complex conceptual analyses, or anticipating or discovering unexpected or provocative findings. Finally, if interviews are the sole means of data collection, conducting more is recommended.

As previously mentioned, with the goal of developing a theory for the studied phenomenon, deciding a specific sample size prior to analyzing the data is impossible. However, estimating a range is possible. Despite Charmaz's (2014) refusal to provide a concrete range of sample size, others have done so. Padgett (2008) states that grounded theory studies should have 20 to 30 participants. Creswell (2014) recommends the same range but also states it could take as many as 60 in some cases. Morse (1994) once suggested the range should fall within 30 and 50 participants, however this range was later reduced to 20 to 30 participants (Morse, 2000). These ranges and the guidelines presented by Charmaz (2014) were used in determining the sample size for this study. Since the population was homogenous in terms of profession, this topic is not controversial, and the analysis was not expected to be overly complex or yield surprising findings, this researcher sought a sample size of 20 participants with the understanding it may be as high as 30 if more clarity is needed. Saturation was obtained at 20 participants, allowing this researcher to stop after 20 interviews. Saturation occurs when the categories are robust enough that no new properties are emerging. In order to ensure saturation had occurred, this researcher followed the guidelines of Charmaz (2014) and ensured that he

defined, checked, and explained the relationships between and among categories as well as the range of variation within and among categories. Although the goal or predetermined estimate of participants is between 20 and 30 people, this could have been altered based on the analysis of the data and clarity of emerging themes.

Recruitment

Recruitment began with a key contact that owns a local agency that employs home-based therapists to reach potential participants. This contact is also part of a network of agencies that contract with the Department of Child Services (DCS) and employ home-based service providers. The network allowed this researcher access to recruit home-based therapists from not only the key contact's agency but other agencies as well since the key contact was able to assist in contacting other gatekeepers within other agencies. This researcher also used snowball sampling, a strategy that obtains participants by asking others to provide researchers with the names of people they know who meet the research sampling criteria (Glesne, 2010). This writer also recruited his own agency contacts using online searches and social work job fairs. As a result, the sample comes from home-based therapists who most likely live and work in the major urban area where many of the agencies are located. Through snowball sampling and his own recruitment this researcher also interviewed participants from different, more rural counties, but all with in the same Midwestern state.

Recruitment began with this researcher making initial contact with his key contact. He outlined the study and got her approval to contact her staff through a recruitment email which she forwarded to her staff and other agencies. This email

explained the study to potential participants and provided contact information for them to reach this researcher.

Upon contact from potential participants, this researcher ensured they met the eligibility requirements discussed below before scheduling an interview. This was done over the phone and through email with questions verifying the caller is a home-based therapist and has a master's degree that allows them to practice therapy. After confirming that the person met all criteria to participate, an interview session was scheduled. This researcher allowed participants to choose the location but advised them that it should be a quiet environment where they feel safe and comfortable discussing their experience within MDTs and discuss different times conflict emerged. As a result, most interviews occurred at their place of employment but several took place in public spaces like coffee shops and libraries. This researcher also conducted several interviews in offices at his university campus.

Because the researcher also used snowball sampling, upon completing interviews, he asked if they know of anyone else who might be interested in the study and ask that they give them this researcher's contact information so they may participate. This researcher always carried extra flyers in his possession when going to interviews to ensure that participants could pass on information regarding the study and his contact information to others that may be interested. Several participants contacted this researcher after hearing about his study from a co-worker or friend.

Applicants needed to meet specific eligibility requirements in order to participate in this study. The first requirement was that participants worked as a home-based therapist. With this requirement came the important task of defining a home-based

therapist as many studies do not share the same terminology or definitions when it comes to those who provide therapeutic services in the client's home. In a study of home-based therapists, Macchi, Johnson, and Durtschi (2014) studied licensed therapists employed as home-based family therapists. Worth and Blow (2010) used a broader approach to defining home-based therapists as they had a sample of therapists who identified as doing therapy in the homes of their clients. Lawson and Foster (2005) referred to their participants as home-based counselors and included those that provided case management as well as those who provided therapy. As a result, their participants had degrees that ranged from high school/GED degrees to doctoral degrees (Lawson & Foster, 2005) whereas the previous studies cited only included therapists with at least a master's degree (Macchi et al., 2014; Worth & Blow, 2010).

For previously mentioned reasons, this researcher actively sought out practicing home-based therapists and followed the lead of Macchi et al. (2014) and Worth and Blow (2010) and only included those who have a master's degree that allows to them to practice therapy. This criterion led to mostly participants with Master of Social Work degrees (MSW) but four participants had Master of Arts in Clinical Mental Health Counseling (MA CMHC), one possessed an Education Specialist degree in Counseling and Counselor Education, and one participant had a Doctorate in Ministry. All participants were either Licensed Social Workers (LSW), Licensed Clinical Social Workers (LCSW), or Licensed Mental Health Counselors (LMHC) (see Table 1 for a demographics of participants in this study). This ensured that the participants in this study were involved in creating, implementing, and evaluating therapeutic goals as well as providing therapeutic opinions about the case that may become potential areas of conflict

with other team members. The second criterion was that the participants must also be able to recall times in which there was some form of conflict within an MDT in which they were members.

This researcher simultaneously recruited participants and conducted interviews. Charmaz (2014) states that this is one of the advantages that qualitative studies have over quantitative ones as those using qualitative methods can add new pieces to the research while still gathering data, even late into the analysis. Recruitment continued until saturation was reached as previously described.

Data Collection

This phase consisted of face-to-face interviews with the home-based therapists using an interview guide and audio recording device to capture the entire interview. Interview questions were created with the aim of understanding collaboration and the process used by home-based therapists to resolve conflict occurring among both the professional team members and team member(s) and the family within the MDT. Participants were asked to reflect upon times when conflict was effectively resolved and times it was not.

Upon arriving at the interview session, this researcher reviewed the consent form with the participants, explained their rights as participants, and answered any questions they may have had about participating in this study. If they agreed to participate, they then filled out a brief demographic form asking them for their gender, age, race, educational degrees and licensure, as well as how long they have been in their current position. Participants were also asked for contact information and if they agreed to be contacted again by this researcher if he needed clarification or has further questions after

the interview is completed as well as for the purpose of member checking, which is described in more detail later in this chapter. When this was completed and participants were ready, the researcher started the audio recorder and begin the interview.

This researcher used an interview guide (see Appendix) and conducted all interviews personally. He asked follow-up questions based on participant's responses. The shortest interview lasted 32 minutes while the longest lasted 90 minutes. The average interview time for all 20 interviews was 63 minutes. As participants could choose interview locations they were conducted at the agencies of the participants, offices on this researcher's school's campus, and within the community. Upon completion, the participants were thanked by this researcher for their time and cooperation. Interviews were then transcribed so the researcher could analyze them. Due to the large volume of interviews, this researcher arranged for an approved transcription services to transcribe the interviews. This researcher reviewed transcriptions by listening to at least ten minutes of the audio recording while reading the transcription before conducting any analysis to ensure the accuracy of the transcription.

Data Analysis

Grounded theory methods were used to analyze and code the interviews. Specifically, this researcher used the approach suggested by Charmaz (2014). As such, this researcher engaged in four levels of coding: initial, focused, axial, and theoretical. An example of this coding process is presented in Figure 1. Overall, the process of coding allows researchers to dissect the data so that they may define it and label it. In grounded theory the researcher develops codes based on what is seen in the data resulting in codes that emerge from the data rather than codes that are placed on the data

(Charmaz, 2014). This researcher used NVivo Version 12, a qualitative data analysis software to aid in the coding process.

The first step of coding is initial coding. In this step the researcher remained close to the data and began to define what was happening in the data. To do this, this researcher used line-by-line coding. In this form of initial coding the researcher assessed what was occurring in each line of data and what were the theoretical implications as a result (Charmaz, 2014). Line-by-line coding does not literally mean that each line is coded individually as not every line will have a complete thought. However, by breaking up events in this way the researcher is able to see potentially ignored or undetected elements which allows for a deeper analysis of what constitutes the concepts being studied, in this case, collaboration and case conflict resolution in MDTs. Engaging in line-by-line coding may also help to shape future interviews and can be used to improve interview questions (Charmaz, 2014). This occurred in this study as the researcher began to ask more follow up questions regarding the perceived role of the participants in resolving conflict. He also began to ask more about the internal thought process of each participant as they decided on how best to approach conflict as different options began to take shape.

In between the initial coding phase and focused coding, this researcher began memo-writing. Charmaz (2014) sees memo-writing as "the pivotal intermediate step between data collection and writing drafts of papers" (p. 162). This practice prompts a researcher to analyze the data and their codes early in the process as well as provide a space to explore the data and converse with one's self about codes, ideas, and even hunches (Charmaz, 2014). Memo-writing for this researcher produced many analytic notes that evolved as more data as collected and analyzed and eventually became the

starting point for different themes and subthemes as well as his proposed model. As the more advanced coding processes are described below it is important to note that memo-writing occurred at each stepped and helped to inform the direction of the analysis and the shape the data began to take.

Focused coding is the second phase of the coding process. It calls for the researcher to analyze the codes produced in initial coding as a means to advance the theoretical direction of the analytic process. Here the emphasis is on the codes that appear more frequently and have greater significance in comparison to other codes within in the initial coding phase. Grounded theory researchers use focused coding to sift, sort, synthesize, and analyze codes to condense and sharpen the work done in the initial coding phase (Charmaz, 2014). Here the researcher used software to help count the frequency of codes. Prior to doing that however, he scanned his initial codes for similar phrasing. An example of this occurred when examining the different feelings that participants experienced when conflict emerged. Codes like “feeling angry”, “feeling pissed”, “feeling ticked off” where all deemed very similar and put under one code of “feeling angry.” Once similarly worded codes were combined to one, the researcher examined them all to see which once appeared more frequently and across multiple participants to determine which ones were more important and relevant.

From focused coding the researcher engaged in axial coding which allowed him to create subcategories that define the attributes and characteristics of the emerging categories. The purpose of axial coding is to bring the data back together after it has been fragmented in the line-by-line coding stage (Charmaz, 2014). This may be best demonstrated by examining the different response options that participants discussed. In

the initial coding phase, there were multiple approaches and responses to conflict that home-based therapist utilized when addressing conflict that this researcher coded. In focus coding he was able to combine a couple of approaches that were similarly worded. As these approaches were examined deeper it was clear to this researcher that there were distinct categories when it came to how participants responded to conflict, which itself appeared be a significant part in the process of conflict resolution. More will be presented in Chapter IV but the categories letting it go, waiting and seeing, and confronting, which itself had two categories emerge in this coding phase, emerged from axial coding under the larger theme of responding to conflict. This also occurred while coding participants initial reactions to the emerging conflict as two different types of reactions emerged as separate categories, one for feelings and one for thoughts.

Finally, theoretical coding aids in theorizing the data and focused codes. Theoretical coding is integrative, lending form to the initial, focused, and axial codes that have been selected. This process also helps to determine potential relationships among the categories that were constructed in the focused coding phase and highlight process (Charmaz, 2014). It was in this phase that the model, which will be presented in Chapter IV and is shown in Figure 2, began to take shape as many of the themes were connected and there was a process and order in which participants engaged in conflict resolution.

As the researcher looked at the data as a whole during this phase, he began to see not only a relationship between many of the major themes but a causal relationship. Thus, the theme of emerging conflict which was constructed in previous coded was seen to result in an internal reaction from the participant which was another theme. These realizations continued with subsequent themes and after many discussions with his peer

debriefer, committee members, and a select group of participants, as well as conversations with himself through memo-writing, this writer was able to produce a proposed model of how home-based therapists engage in conflict resolution (see Figure 2).

This writer used earlier memos about the process of participants experience conflict and reacting to it to aid in this process. As the model began to take shape, this researcher would go back to transcripts and compare his model against what participants were reporting about their experiences in both conflicts that resolved well and conflicts that did not resolve well. This process helped to confirmed that the model was true to the data and aided in ensuring that represented the overall process, not just one person's or the conflict experiences of only those conflicts that were positively resolved.

Data analysis and collection occurred simultaneously with each process influencing the other. Also, within the coding phase, the researcher engaged in the constant comparison method meaning that comparisons were made both within individual interviews and across all of the interviews (Charmaz, 2014). Within this method, data is compared at multiple levels meaning that initial codes are compared to other initial codes found in other interviews as well as focus codes (Birks & Mills, 2015). Following Charmaz (2014), comparisons were made between data collected early in the study and data collected later as well as testing preliminary ideas by comparing data in order as a means to test categories and potential theories meaning that as themes began to emerge from earlier interviews they were compared to later ones. Again, this proved to be particular helpful in developing the model which went through several iterations

throughout the coding process as it became more complex and nuanced as the researcher developed a deeper understanding as the data grew.

Rigor and Trustworthiness

Ultimately, what makes a study rigorous is its ability to address potential threats to trustworthiness such as reactivity, researcher bias, and respondent bias (Padgett, 2008). As this researcher has past professional experience and has conducted a thorough literature review on the topic, the threat of researcher bias is strongly addressed in this study. Qualitative researchers can implement different techniques to address threats to trustworthiness. The researcher used memos consistently, created an audit trail, utilized peer debriefing and support, and provided a thick description of his process.

Researchers can avoid their own bias by creating an audit trail. In this approach, researchers document each step in the data collection and analysis process. Providing an audit trail allows a fellow researcher the opportunity to come as close as possible to recreating the study (Padgett, 2008). This researcher documented his process materials such as coded transcripts and memos about his decision-making during formation of the interview guide, data collection, coding, and analysis. These documents were reviewed with the researcher's dissertation chair and his methodologist as well as a fellow PhD candidate who practices home-based therapy.

Additionally, this researcher also kept a journal of his thoughts early on in the research process about what he might expect and ways to avoid introducing bias into his data collection and analysis. This was particularly important for this researcher considering his past experience as a home-based therapist working within MDTs where he experienced varying degrees of conflict with child welfare caseworkers about topics

ranging from required services to case closure. These conflicts have been met with different approaches and led to varying results. He has expressed his difference of opinions in family team meetings, with individual service providers, and in court. At times these conflicting recommendations were met with acknowledgement and taken to the court for an ultimate decision while other times the conflict was essentially ignored with no changes made essentially forcing a decision to just be deferred for a later time. It is experiences like this that, though they began this researcher on the path to this particular topic and study, must be acknowledged and addressed to ensure that they do not overtake the experiences of the participants during data analysis.

In addition to his personal experience this researcher also has developed a great deal of a priori theoretical knowledge due to his in-depth study and analysis of the relevant literature. This knowledge may also lead to a bias when examining the data, which needs to be acknowledged and combatted. As a result of these different personal experiences and research into the study topic, the researcher acknowledges that he comes to this study with preconceived notions and expectations about what he might find. This is where Charmaz's (2006) constructivist approach to grounded theory is important because, as she points out:

> Thus, constructivists attempt to become aware of their presuppositions and to grapple with how they affect the research. They realize that grounded theorists can ironically import preconceived ideas into their work when they remain unaware of their starting assumptions. Thus, constructivism fosters researchers' reflexivity about their *own* interpretations as well as those of their research participants. (p. 131)

As a way to fully examine any preconceived ideas about this topic this researcher engaged in journaling throughout the study. Early in the process of conceptualizing this study this researcher focused his journaling on his own experiences with conflict in MDTs and what he thinks he might find. In addition to this, he attempted to write down strategies to ensure that he was not letting he own experience shape his coding or interpretations of others' experiences. He continued to use journaling as the study progressed and data collection occurs. This occurred at different times as he wrote entries after each interview about overall impressions and his own reflections. As the study processed this researcher began to engage more in analytic memoing as described previously because he began to make connections between interviews and would memo after coding each interview. He also wrote memos after doing the initial coding of each interview as well as throughout the entire coding process in addition to other times the researcher was working on this study as way to explore ideas about emerging codes.

Memos are also a vital part of grounded theory as they help to keep the researcher involved in the analysis and can aid in increasing the level of abstraction regarding ideas about coding, concepts, and categories (Charmaz, 2014). In general, memos may also be used throughout the entire study to help the researcher increase awareness regarding any biases that may impact the study (Padgett, 2008).

Prior to conducting any interviews with participants, the researcher conducted a pilot interview with a former home-based therapist. He developed his interview guide and sought feedback from his committee members who all approved. He then conducted an interview with this former home-based therapist and sought her feedback on the entire process, including the length and content of the interview. The researcher engaged in a

conversation with her about the interview process and they both agreed that questions prompted her to engage in the in-depth conversation that would be needed to for this study and the process was not too longer or cumbersome. This opportunity also allowed the researcher an opportunity to fine tune his approach in reading the consent portion and the questions to the participants, ensuring that he was prepared to conduct interview for analysis.

Qualitative researchers also use peer debriefing and support. This allows researchers the opportunity to get important feedback regarding their methods, interview questions, and other elements of their study. This, like memos and audit trails, also helps to reduce researcher bias (Creswell, 2014; Padgett, 2008). This researcher engaged in this practice as he met with a selected PhD candidate who was also a representative from the field to discuss his study. This allowed her to have a unique perspective with the research background and practice experience needed to understand this study and its findings. This person assisted the researcher in both the coding process and the development of the proposal model which will be presented in the next chapter. During this initial coding process this researcher provided a deidentified transcript to his peer so that she could also code it. Both coded transcripts were compared and found to have agreement. Following this step, the researcher presented several other coded transcripts in peer debriefing sessions to ensure that he was still accurately and appropriately engaging in the coding process. This process continued through theoretical coding and the development of the model. The model went through several iterations with the researcher getting feedback throughout the way from committee members, his peer debriefer, and a 5 of his participants, along with a former home-based therapist who helped him in piloting his

interview guide. All provided positive feedback and did not disagree with the model based on their own experiences or the data.

Additionally, providing a rich and thick description adds to the trustworthiness of a qualitative study. When this is accomplished, the researcher has provided a means for the reader to enter the research context, allowing the reader the chance to make their own decision regarding the transferability of the study (Creswell, 2014; Glesne, 2010). This is done in this study first by gathering rich data in the interview process. Charmaz (2014) states that questions that lead to reflection elicit rich data. These questions often include "tell me about" and "what" which is primarily what the researcher used in his interviews, asking participants to tell him about a conflict and following up with asking about what happened next. Additionally, when presenting his findings in the next chapter this writer ensured to include many quotes so the reader can see how the researcher came to that particular theme and can judge for themselves the appropriateness and transferability of that theme and this study as a whole.

Finally, member checking was also used to ensure that the researcher is accurately capturing the content and nature of interviews with home-based therapists. Member checking involves providing interviewees with transcribed and coded interviews and allowing them the opportunity to provide any clarification or corrections to the researcher (Lincoln & Guba, 1985). It also can guard against researcher bias (Padgett, 2008). Charmaz (2014) discusses its benefits beyond confirmation from participants as member checking can also help a researcher elaborate on emerging categories. By utilizing this approach, the researcher is introducing another checkpoint to ensure that he is staying true to experiences of the participants in this study.

Participants were provided their transcribed interview and coding report to ensure accuracy of what they said and meant. This process was done through email with no participant questioning the accuracy of the transcript or initial codes. In addition to this confirmation process the researcher followed Charmaz's (2014) practice of using member checking to help with emerging categories. This was also done through email with a selection of five participants who agreed to hear about emerging themes and provide feedback throughout the study. This is where this researcher shared his model and outline of major themes and received positive feedback.

Evaluating Grounded Theory Studies

In addition to the rigor and trustworthiness of qualitative studies in general, Charmaz (2014) outlines four criteria for grounded theory studies to be evaluated: credibility, originality, resonance, and usefulness. Charmaz (2014) states that a strong combination of originality and credibility increase both resonance and usefulness, thus increasing the study's overall contribution.

Credibility is achieved when the researcher has achieved intimate familiarity with the topic and there is sufficient data to merit claims made. This researcher was able to do this through his 20 intensive interviews, reaching saturation, and engaging in rigorous data analysis and memo-writing throughout the process. Credibility is also achieved, according to Charmaz (2014), when the study has strong logical links between the data the researcher gathered, and the argument and analysis presented. Additionally, there should also be enough evidence that readers can come to their own conclusion and ultimately agree with the researcher's claims. This study also achieves this benchmark as

many quotes are presented for the reader as well as information on the researcher's coding process.

Originality, the second of Charmaz's (2014) criteria, is obtained by presenting new categories and insights, as well as new conceptual renderings of the data. There must also be a sense of social and theoretical significance with the theory presenting either challenging, extending, or redefining current ideas, concepts, and practices. Here, this study presents a new model for conflict resolution in child welfare MDTs based on the previously understand profession of home-based therapist. While some of these concepts have been studied before, the idea of presenting the process in which home-based therapist experience and attempt to resolve conflict within child welfare MDTs is a new addition to the growing literature.

Resonance is the third criteria and is defined by categories representing the fullness of the research topic and offering deeper insights in the lives and worlds of those studied (Charmaz, 2014). This study provides a deep description of the conflict resolution process described by participants. By asking participants about both conflicts that ended with a favorable resolution and an unfavorable resolution, this researcher was able to collect data on the fullness of conflict resolution, meeting the resonance criteria.

Finally, usefulness in grounded theory studies consists of offering interpretations that people can use in their everyday lives and can be measured by the how the study contributes to the knowledge base and to improving the world (Charmaz, 2014). This study also meets this benchmarks as this researcher believes that better understanding conflict, how it emerges, how professionals react to it, and what strategies may be uses to resolve it are vital in the child welfare team where conflict among team members is likely

to occur. Understanding this process should help all professionals navigate it more efficiently which should ultimately help the families they serve. Improved working relationships among professionals should help to combat some of the traumatic effects the child welfare system can have on families and children while simultaneously improving the efficiency of its work with families (Lalayants & Epstein, 2005; Wolfteich & Loggins, 2007). Speedier conflict resolution could also lead to shorter cases in the child welfare system without sacrificing the quality of services or safety for children. This could lead to children spending less time in foster care which has both social and financial benefits to society.

This specific subject matter has not been well researched, so the module constructed from this work has great potential to add to or refine theories of conflict resolution. It also has great social and theoretical significance within the child welfare field as it can improve the functions of MDTs. It can provide team members with a deeper insight into how they resolve conflict within their MDTs.

In addition to the four criterion outlined above, Charmaz (2014) also states that grounded theory studies need to produce a theory. Thus, the final product of a grounded theory study is a theory which Birks and Mills (2015) state is integrated, comprehensive, and "explains a process or scheme associated with a phenomenon" (p. 13). This researcher was able to produce a proposed model as a result of engaging in this process that explains the process home-based therapist participate in when they experience conflict with other professionals in child welfare MDTs.

Conducting Ethical Research

Ethics are an important part of any study. Efforts must be made to ensure the researcher conducts himself and his research in an ethical manner. One way to do this is to ensure confidentiality. Not using participant's real names and removing any identifying information from transcripts accomplishes this and was done in this study. Also, all data were kept on a password protected computer. Finally, all recordings were destroyed after they were transcribed, verified to be accurate, and no longer needed for the analysis process.

Informed consent is another factor of ethical research. This researcher obtained informed consent from each participant prior to the start of interviews. In addition to informed consent, participants could have ended their participation in the study at any point during the study. This was explained to participants who were also asked if they still wish for their interviews to be included in the study at the conclusion of each interview. Member checking was used as a means to improve the trustworthiness and rigor of the study, but it also has ethical elements to it as well as it ensured that each participant is accurately portrayed and allowed them another opportunity to give their continued consent to the study.

Finally, ethical research should ensure that the benefits of the research outweigh the cost of participation. This researcher believes that engaging in a better understanding the role of conflict within child welfare MDTs and the process of resolving that conflict can provide numerous benefits to the child welfare system, the families impacted by it, and the professionals who engage in it. Engaging in qualitative interviews can also be enlightening for the participants and several stated gained a better understanding of their

own perceptions of conflict and the approaches they use or avoid in addressing it. Interview questions were not overly personal and should not bring up any traumatic memories for the participants as they are mostly professional in nature. As such, these interviews appeared to be easy for participants to engage in and share their experiences in response to each question. These benefits seem to far outweigh the cost of taking roughly an hour to discuss this topic with this researcher.

Chapter IV: Findings

The findings in this study emerged from roughly 3,000 coded items from 20 transcripts. These findings help to answer the research questions of: 1) What do home-based therapists perceive to be important facilitators and barriers to collaboration for child welfare MDTs? and 2) How do child welfare home-based therapists resolve conflict once it emerges within the MDT? Throughout the coding process it became clear that these questions are linked and that the level of collaboration can impact conflict resolution, both in its process and its timeframe which is explained in more depth in this chapter. Through the participants' words it became clear that a strong collaboration between team members can help them to address conflict in a more productive and timely manner. Before examining the findings of interviews, it is important to discuss the participants that made up this study.

Participant Demographics

This study consists data from 20 participants, all of whom were currently involved in at least once case where they were the home-based therapist (see Table 1 for a breakdown of participants) at the time of their interview. One participant, Tiffany (pseudonyms are used throughout), was primarily a supervisor but still engaged in a small caseload where she provided home-based therapy. All participants had a least a Master's degree: sixteen participants have Master's degrees in Social Work (MSW); four have Master's degrees in Clinical Mental Health Counseling (MA CMHC); one possesses an Education Specialist degree in Counseling and Counselor Education; and one has a Doctorate in Ministry (DMin). Ten participants were Licensed Social Workers (LSW), four were Licensed Clinical Social Workers (LCSW), and 6 were Licensed Mental

Health Counselors (LMHC). Four participants identified as male and 16 identified as female. The age of the participants ranged from 24 to 62 with an average age of 38 years old. Experience also varied greatly, as participants in this study had anywhere from 4 months to 21 years of experience practicing home-based therapy. The average length of experience was 4 years. A total of five participants were in their first year of practice as a home-based therapist but 9 participants had 4 or more years as a home-based therapist at the time of the interview.

Finally, there are seven agencies represented in this study. All agencies contract with county Department of Child Services offices to provide services to individuals and families. Seventeen participants worked for local agencies (Agencies A-D) as salaried employees, while three participants worked for agencies as independent contractors.

Table 1: Demographic of Participants (N=20)

	Pseudonym	Race	Age	Home-Based Therapy Experience (in years)	Degree	Credentials	Agency
1	Lily	White	41	6	MSW	LCSW, CSAYC	A
2	Melissa	White	34	.25	MSW	LSW	A
3	Edward	White	27	.33	MSW	LSW	A
4	Allison	African American	33	6	MSW	LCSW, CSAYC, TF-CBT certified	A
5	Elizabeth	White	29	3	MSW	LSW	B
6	Ben	Asian American	40	6	MSW	LSW, CSAYC,	A
7	Emily	White	37	4	MSW	LSW	B
8	Destiny	African American	62	5	DMin	LMHC, CCFP, CATP	G

9	Savannah	African American	62	5	MSW	LCSW, TF-CBT certified	E
10	Dave	White	25	.5	MA CMHC	LMHC	F
11	Monica	White	35	7	MSW	LCSW	B
12	Victoria	White	56	1.5	MA CMCH	LMHC	C
13	Kim	White	26	.5	MSW	LSW	C
14	Sarah	White	46	3	MA CMCH	LMHC	B
15	Tiffany	White	45	21	MA CMCH	LMHC	C
16	Maria	Latina	24	1.8	MSW	LSW	D
17	Julia	White	31	5	Ed.S. - Counseling - Counselor Ed.	LMHC	C
18	Adam	White	37	3	MSW	LSW	A
19	Diana	White	38	1	MSW	LSW	D
20	Tabitha	African American	34	.9	MSW	LSW	D

Identifying Major Themes

Many themes emerged from the data that helped to answer the research questions. Many of these themes are not independent of themselves as they can influence each other. These relationships will also be explored as each theme is examined in more detail. These relationships also helped to influence the model of addressing conflict (see Figure 2) which will be presented at the end of this chapter. It was through the grounded coding process that this model began to take shape as it was clear that the themes that emerged from the coding process were related to each other and had a process to them. Before presenting the model, it is important to examine the themes that emerged from the data. These themes are presented in Table 2 and will be discussed in detail throughout this section.

Table 2: List of Major Themes

Themes	Subthemes	Codes
Factors Influencing Collaboration	Communication Openness Trust Mutual Respect	
Emerging Conflict	Views of Conflict	
	Types and Causes of Conflict	Conflict due to system issues Conflict due to interpersonal issues within the team
Internal Reaction and Response	Feelings	Feeling Frustrated Feeling Anger Feeling Shock Feeling Uncomfortable Feeling Attacked
	Thoughts	Doubting Self Doubting Team
Making a Decision	Weighing Pros and Cons	
	Bringing in Ethics	
Responding to Conflict (Action)	Letting it Go	
	Waiting and Seeing	
	Confronting	Choosing When to Confront (Real Time vs Retroactively) Choosing How to Confront (Strategies)
Team Reaction	Responding Positively	
	Responding Negatively	
	Ignoring	
Result/Team Decision	Agreeing with Participant	
	Disagreeing with Participant	
	Going to Higher Ups	Going to Supervisors Going to Judges
	Outside Factors	
Engaging in Self-Reflection	Reflecting and Learning	

Many themes have multiple subthemes that emerged through the coding process. Figure 1 demonstrates how this researcher started with the participants' words found in the transcripts of the interviews and went through the coding process. To demonstrate

this, I chose one theme, initial reaction, and one subtheme, anger. As such, some aspects of the initial reaction theme like the other subtheme of thoughts and the aspects of feelings are left out of this figure for simplicity.

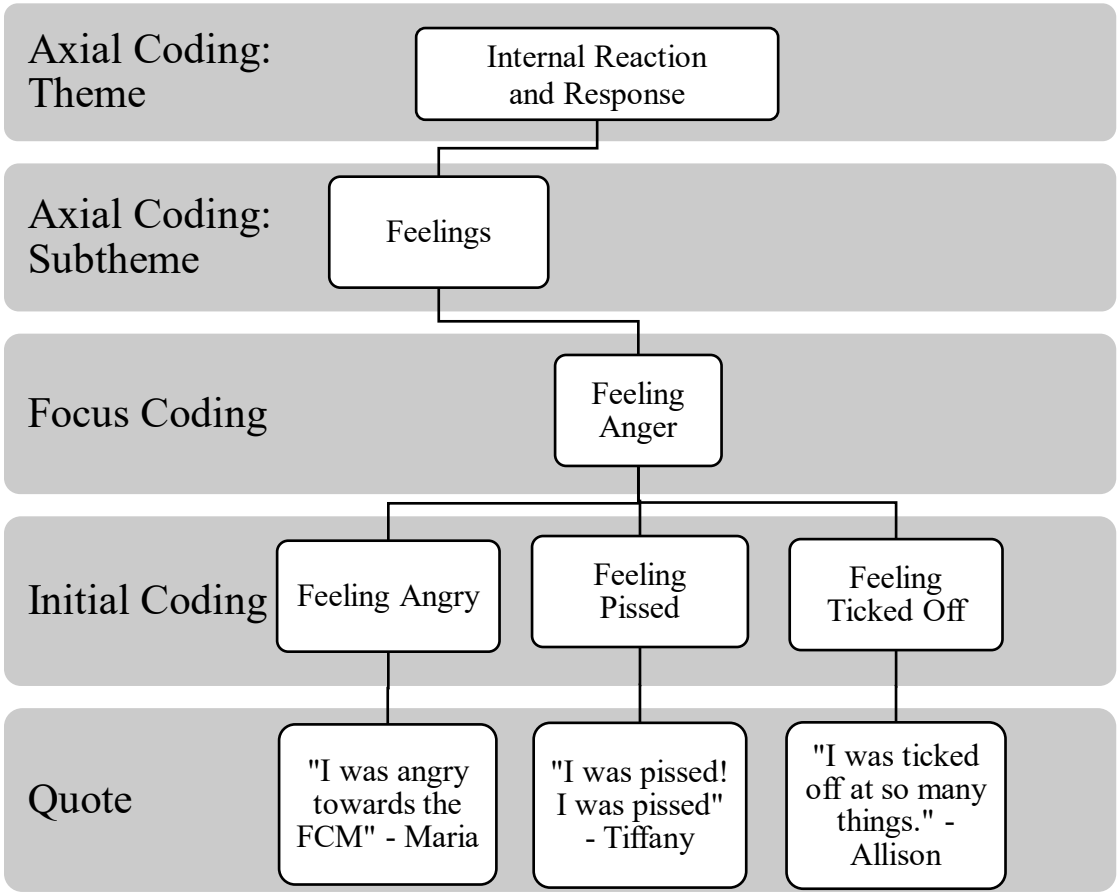

Figure 1: Example of Coding Process

Factors Influencing Collaboration

Participants discussed their experience with teams that had both strong and poor collaboration. In trying to find common factors that may lead teams to have better collaboration, certain case characteristics such as number of professionals on the team or the complexity of the cases were considered but ultimately ruled out. It appears that these

are not necessarily contributing factors or prerequisites to collaboration as participants provided examples of large teams with complicated cases as having both strong and poor collaboration as well small teams with simple cases as having both strong and poor collaboration. The biggest contributor to having a team with good collaboration according to participants seems to be the team members themselves, providing they had the proper characteristics presented below. If team members and the team as a whole had these features, then collaboration was likely to occur. Teams that struggled in these areas often had poor collaboration. As such these features are both contributing features to collaboration but when they are lacking or when their opposite is present it is a barrier to collaboration.

Communication. Communication emerged as a key characteristic in a team with strong collaboration. Participants talked about having communication that was clear, open, and fair with teams that they collaborated well with. This communication also needed to be timely and would occur at meetings, in phone calls, and through emails. Participants talked about the importance of keep the team updated on the progress they were making or not making with their clients and when a whole team is engaging in collaboration, other providers and team members do the same. Tiffany talked about how she ensures that she keeps her team in the loop of the work she is doing with clients as she discussed the subject of her weekly emails that go out to the whole team,

> Just larger scale…you know, larger scale – have you done this? Have you done that? What direction are we moving in now? How are those meetings going that you're having on Monday? How is individual going? How's case management/recovery going? That type of thing

Tiffany's agency valued constant communication greatly and even made it an agency policy that all employees would send weekly email updates to their teams in addition the

required monthly reports to DCS. Others that worked for the same agency also spoke of this policy.

Even when it was not policy to email the team on weekly basis, some participants stated this is what their teams did organically out of need. Often times, the participants could not recall how the email chains or system started or if there was a conscious effort in the beginning by anyone. They stated it just kind of started and once one person did, others followed suite.

Kim provided an example of how collaboration is a team effort. She engaged in consistent communication with her team and others did as well, making it a true collaboration. Kim described how a visit supervisor kept the team in the loop,

> So with that visitation worker outside of talking to the FCM, she would also email me or the case worker with different things that she had noticed or witnessed or maybe – cuz she would spend like six hours a day with them and I'd only get like two a week, so she would tell me like, 'oh, she said this to me, you might want to find a way to address that with her.'

This quote also shows how collaboration, and in particular constant communication, can help the therapists in their work as they have more up-to-date information and issues to address with their clients in therapy. This is something that was echoed by many other participants, like Diana, who appreciated what good collaboration could do for their therapy sessions with clients. Diana talked about the importance of good communication and timely information sharing stating, "that has kept me able to address things on a consistent basis, to kind-of head-off crisis, to intervene when necessary."

Openness. Another important feature of collaboration is that the team members had to be open to the idea of it. They had to be willing to put forth the effort to communicate on a regular basis and be open to hearing people's ideas and

recommendations. Julia talked about a particular FCM whom she has worked with many times before and really appreciated because she is very open to what Julia has to say and recommend. Her quote highlights this and also that this has not always been her experience with professionals.

> I've just been able to really say like what's best for the family or not best, you know? And say I think we need to hold back on this, I think they need this…and I really appreciated her because she's always been so receptive…and she can come to me and say hey, you know, I really would love to move this family forward, what do you think? And if I say they're not ready, then she's like ok, I'm on board – I want to get them off my case load, but if they're not ready, that's ok, but you know? And I appreciate that about her because that's not always the approach.

Being open also involves team members being able to discuss issues with each other. Julia expressed her desire to demonstrate her openness and he hope that others do the same, "just the expectation of hey, I'm here and I'm open. If you need to address something with me that you don't think is accurate, please just talk to me about it." This also demonstrates that teams need to be open not in just how they communicate and share differing opinions but have to open up to the notion of collaboration in general. Dave expressed openness to collaborating with others and his hope that others feel the same way by stating, "I want us to be a cohesive team, but I also want people to understand each other's viewpoints. I want people to be able to speak up."

Trust. Trust is also an important feature of collaboration, part of which is trusting that each individual on the team will do their job and do it to the best of their ability. Diana talked about what that trust looks like as she describes a home-based case worker she has a trust in, "I can understand like this case worker's gonna pick up on this, they've got this, I don't need to worry about it." Adam took this notion to the entire team as he believes that when a team is collaborating, everyone is willing to do their part as he

shared, “but I think generally, you know, people know they’re there for a reason and they’re trying to help out any way they can.”

Monica talked about how trust can be earned over time as the team works together. Using herself as an example she stated,

> I think the dependability piece is really huge where if they know they have a problem with a client and they can call me and I can take care of it, you know, then we’re much more willing to work closely together and then vice versa.

This also points to a cyclical dynamic of trust and collaboration, as many participants spoke about trust in terms of both an outcome of collaboration and a prerequisite as well. The more teams work together, the more they trust each other or at least provide reasons to be trusted as Monica state but there also has to be that initial trust to start collaborating. This came naturally to the participants who spoke of trust and exemplified by Adam who stated that he believed “people want to do good and so they’ll do those things” when talking about trusting his fellow team members, even if they have contradictory roles to his.

Mutual respect. Finally, mutual respect helps to contribute to strong collaboration. Participants talked about the need to respect each other in order to fully listen and consider each members’ opinion or recommendation as well as sharing their own recommendations in a respectful manner. Melissa talked about how this was at times hard for her as new therapist, especially when her client was regularly sharing her frustration with her. She recalled how she kept respect in her work with the FCM, “I had to be really mindful of respecting the FCM’s position in a way where I wasn’t letting the client’s opinions kind-of influence how I was working – that was really tricky in that case, especially as a new provider.”

Respect, like all the aspects of collaboration can change over time. When developing a strong collaboration, participants talked about gaining team members' trust by following through on what they said they would do, showing that they can communicate respectfully, and showing that they are qualified and can be helpful assets to the team. Monica experienced that mutual respect among her team grew over time stating, "I think they had a level of respect for me and I had a level of respect for them that had increased over the weeks because of our communications with one another and collaborating."

Conflict Emerges Within the MDT

Views of conflict. Before going into more detail about the types of conflict and how conflict can present itself, it is important to note how participants viewed conflict in general. Their views of conflict may influence how they react to it when it occurs. Some participants in this study stated, without prompts, that they were very comfortable with conflict and though they would not seek it out, they would not back down either. Others also stated without being directly asked that they were conflict avoidant and sometimes become uncomfortable when it emerged in their teams.

Overall, the majority of participant had a negative view of conflict. Participants used many negative words to describe the conflict they experienced such as "unnecessary", "inappropriate", "wasteful", and "an injustice to clients". Others described the toll it can take on the client and themselves as "jarring", "a constant challenge", and "emotionally draining". Tabitha described how she felt after conflictual team meetings stating, "I'm like ugh, it's so draining – I left that meeting feeling exhausted – like I ran a marathon or something – seriously." Destiny also talked about the

toll that conflict has on her work, stating that "I think with me it's just a constant challenge – just a constant challenge trying to work with everybody and not be so frustrated that you just wanna say forget it." Participants were also able to observe and describe the impact that conflict has on other members. Dave discussed how it makes people defensive because it can "catch them off guard…and they feel attacked." While Destiny stated it can impair judgment because "they're just tired of talking about it, they just wanna end it, kinda already closed their minds."

Despite this relatively negative outlook on conflict, several participants indicated that conflict can be much more nuanced. Adam seemed to articulate this in real time when asked about what he thought of conflict responding, "I think it's bad. Well, not *all* bad, ok – I'll take that back, I think that it can be useful, but it can become in such a way that it isn't useful." Here we see how some conflict may have a purpose, provided it is handled in the right way. Dave, though relatively new to home-based therapy, already shared this view stating, "I think conflict is not only inevitable, but it's sometimes necessary when working with a team." He made sure to clarify that it needed to be what he called "healthy conflict" which is not driven by ego. It also had to be addressed appropriately and not ignored. Similar to Dave, several participants made it a point to state that conflict itself is not necessarily negative.

Some participants, like Lily, even talked about how they can use it in therapy with clients. Lily and her client both struggled with how another therapist was talking to Lily's client in their jointly led couples counseling sessions. Lily, though extremely frustrated with this other therapist, was able to see it as a way to practice the anger management skills she was working with her client on in therapy stating, "in some ways it was useful

because we could play out the same stuff – like, ok, we're walking into a situation and this might be difficult – how are we gonna use your skills?" However, she still found the conflict she experienced in this case unnecessary and not a productive use of time, energy, or focus of her work with the client stating that, "it was good practice, but we didn't need to be spending so much time – it was just extra that we could have been focusing on other things and so it was kinda wasteful in that way." Dave also saw the danger of conflict if not properly addressed stating, "I feel like it's sometimes…it's us versus each other instead of us versus the problem." This speaks to the complicated nature of conflict within these MDTs as it is both expected but unwanted, though still viewed as potentially useful depending on the situation and how it is managed.

Participants also saw themselves as uniquely qualified and even called to ensure that conflicts were addressed professionally. Many participants saw their role as an advocate for their clients and saw addressing conflict as part of this role. They also felt that they brought therapeutic skills that could aid in addressing conflict and ensuring that all members felt heard, respected, and support, even as they disagree.

Types and causes of conflict. Participants discussed a variety of causes of conflict that arose during Child and Family Team Meetings (CFTMs), providers meetings, individual interactions before court hearings, and through emails. The conflict described by participants can be broken down into two main categories: 1) conflict due to system issues and 2) conflict due to interpersonal issues within the team.

Conflict due to system issues. System issues are largely logistical in nature such as conflict due to bureaucratic issues or rules, consistent team turnover, and teams with a high number of service providers. Not all participants discuss these causes and in fact,

some discussed these factors in cases that did not have any conflict, indicating that certain teams and individuals are more equipped to deal with frustrating or potentially conflict-inducing situations better than other teams.

Perhaps the most prevalent cause of conflict resulting from the overall system of child welfare MDTs was because there are multiple team members with various roles and sometimes different and sometimes competing clients who all wanted to share opinions and recommendations. When two team members have two different clients within the same family, they may have different information and/or perspectives. This can lead to disagreements on next steps or the overall direction of the case. Participants spoke about this type of conflict in much more neutral terms than other forms of conflict. Some participants even went so far as to say they expected it. Dave said this when discussing these disagreements with other team members, "conflict is always inevitable and just learning how to deal with it as it comes up. I don't think there's ever a 100% way to prepare for conflict, you just always have to know how to deal with." He even added later that it was "sometimes necessary when working with a team." Others spoke about this expectation and as long as members were able to remain respectful and professional, they did not seem to mind being on different sides of an issue. It was only when the communication became aggressive, personal, uninformed, unprofessional, or unproductive in some way that tension seemed to rise.

Though home-based therapists may expect conflict with other professionals on the team as the case progresses, Julia questioned if that was the case for other providers. She felt like those new to child welfare are prepared for conflict with families but not their

fellow team members. She also wondered if FCMs were prepared for conflict with home-based therapists. She offered her reasons why stating,

> When it comes to those professional relationships, I don't think they're expecting that [conflict]. I think for two reasons – sometimes I think it's because FCMs just expect like we work for DCS technically, so they just expect us to do what DCS recommends and then the second reason is I just don't think a lot of them even understand what the role of a service provider is. I don't think they get a lot of…background or education in their training about what our role is with the family

Having one member expecting and accepting the need for conflict while the other is not can lead to tension in the relationship. If Julia's hypothesis is correct, then a home-based therapist disagreeing with the FCM or a DCS recommendation would be a source of conflict and could lead to a power struggle.

Additionally, participants spoke frequently about advocating for their clients, if other members are doing the same and the clients have opposing objectives, this can put the two team members at odds. These conflicts seemed to manifest themselves mostly between the home-based therapists and the GALs or CASAs. When describing this issue, Julia put it this way,

> They [CASAs] have one role with the family and I think sometimes they expect us to take the same role whereas ours is very different – just like the CASA's is very different and that's the reason you have all of those people on the team.

When team members fail to recognize that each member has a professional and ethical responsibility, independent of their own, it can lead to difficult conversations. Having multiple providers also increases the chances of miscommunication or lack of communication which can also lead to conflict.

Conflict due to interpersonal issues within the team. Conflicts due to interpersonal issues within the team arise because of the way an individual team member or members

conduct themselves within the team. Thus, there were examples of conflict that occurred based on professional roles within the team and specific case circumstances (system issues) but there was also conflict based on the actual individuals making up the team (member issues). As I have alluded to already and will continue to show, participants believed that, at times, conflict based on system issues were unavoidable, even if everyone was doing their best and acting in a professional and ethical manner. However, conflict based on interpersonal issues could be avoided if perhaps the team's makeup was different, or people conducted themselves in a different manner.

Participants also discussed several characteristics or actions of team members that can lead to conflictual interactions within their MDTs. Some of these factors originated from what the home-based therapists perceived to be personality traits. Examples include team members who were described as gruff or as having a difficult or awkward affect. More commonly though, participants spoke of issues resulting from what they saw as unethical or unprofessional behavior from team members. This often took the form of perceived bias towards the participant's client. One participant, Melissa, recounted a time where there was conflict between her and the rest of the team because they were already dismissing the mother as a viable option for reunification and were clearly biased against her, already preparing for adoption only a few months in the case. Melissa, who was not the mother's therapist, still saw this as unethical since they were supposed to be working towards reunification at this point in the case. However, she received pushback and negative looks when she brought this up to the team. She felt like the team had an ethical obligation it was not living up to and she appeared to be the only one upset by this.

Instances of being combative towards a participant's client or having multiple team members gang up the client were often cited as another cause of conflict. This can be problematic because as Emily pointed out, this does not sit well with clients and it is often up to the home-based therapist to help the client navigate this negative interaction in an appropriate manner. She described one instance with a CASA "interrogating" her client by saying, "she puts her down a lot and so that creates tension in the team meetings because my client gets heated and then I gotta calm her down and then – and so it's a problem."

Other participants found that conflict emerged when other professional team members did not behave professionally or complete their job responsibilities. Frustrations grew as FCMs failed to communicate with the team or follow up on recommendations. Others talked about seeing signs of burn out in workers and lack of engagement, while others even had interaction with CASAs, GALs, FCMs, and other therapists that made them question their training, education, and overall fitness for their position.

Internal Reaction and Response

Once the conflict emerged, participants spoke about their initial, internal reaction. This included processing both feelings and thoughts. As participants shared their initial reactions, many were also quick to share how they attempted to not let these reactions influence their decisions or response to the conflict. They wanted to remain professional in their interactions with their fellow team members, even with the team member that was causing them to have negative feelings or thoughts as a result of the conflict. As such, it appears that therapists attempt to engage in emotional regulation to ensure that their own

feelings or thoughts do not interfere with their work. Thus, they not only reacted to the emerging conflict but also responded to their own reactions along the way.

Feelings. All participants discussed the varied feelings they experienced when a conflict first emerged within their MDTs. These initial internal actions varied but like the views of conflict were almost entirely negative. One participant stated she was excited for the challenge the conflict brought but this was addition to a more negative feeling. Overall, the most common feelings were of frustration, anger, and shock as well as feeling uncomfortable and feeling attacked.

Feeling frustrated. Of the 20 participants, over three quarters of them used the term frustrated to describe how they felt because of the conflict. The reasons behind their frustrations varied among the participants but ultimately related to the reason for the conflict. Some participants became frustrated when they felt like the team was either not taking their concerns seriously or were rushing the case towards closure without fully addressing all concerns. Kim stated that "I was just frustrated that they – I guess I felt like they were more concerned with case closure than with the actual safety of the home." Allison stated that her frustration over the conflict her team experienced regarding case closure stemmed from the fact that she felt the team was focusing more on the "checklist" than progress of the parents as they decided what to do. Tabitha took it a step further when describing her initial frustration with a conflict in which she felt ignored by her team stating, "I also feel like they don't listen to me, so they just kind-of listen to themselves, so that's frustrating as well." This also speaks to a general feeling of being dismissed by team members which several participants stated they experienced as conflicts emerged.

Another common cause of the frustration occurred when the participants felt like their fellow team members were not doing their jobs or were not putting forth the same effort as the participant was. Julia summed this up stating,

> I felt like I was really advocating for the family and trying to do my job which is being there for them and getting them the services they need and the goals to achieve reunification and so I was frustrated that another professional was not making that the number one priority. I think that's why I was the most frustrated.

Sarah expressed her frustration of having to be the one to bring a team's focus back to the case and away from "bashing" a client who was not present. She made it clear that she did not disagree with what they were saying but "it was just the fact that it was getting out of control and no one was really doing anything to kind-of rein it back in and that's where my frustration was coming in." She wanted the FCM to stand up and take control of the meeting. This complaint was common among participants, most of whom would make efforts to regain focus themselves but also felt it was not their responsibility. Having to do what they perceived as the FCM's job in team members led to feelings of frustration.

Feeling anger. Nearly half of the participants also expressed feeling angry during conflict. Monica provided good insight here as she described her initial reaction of team members disagreeing about how the case should progress and whether Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) was appropriate for her client's child. She stated,

> I was mad on multiple levels – mad for my client, mad for this kid who's not getting the treatment that he needs and I was frustrated that their understanding of TF-CBT could be warped to meet their goals and ends rather than, you know, going to where the client is at and meeting them where they're at.

This anger speaks to many themes that came up throughout Monica's interview and many other interviews. The role of advocate is present here and the fact that she was trying to advocate for a child to get the services she felt were needed while the client was left in limbo as the team debated placement options and treatment options which angered her. The fact that this child is not her client is irrelevant and multiple participants spoke of times when they advocated for family members involved in their cases that were not actually their clients.

This quotation also speaks to the fact that team members come into their teams with different training, education, experiences, and perspectives related to their role and position on the team. As a therapist, Monica had a strong understanding of therapeutic practices like TF-CBT and what it could do for the child in question. On this team, it appears that others did not, and Monica spoke about trying to educate them more about the process and the need for a certified and experienced therapist. Monica also has the social worker perspective of meeting the client where they are at, something that may not be the priority or driving force of other members.

Anger not only arose due to conflicts over services recommendations but also over when to close a case. Melissa discussed her anger that emerged over a conflict with the FCM about Melissa's decisions to close services. As she described the conflict, I asked about her initial reaction to it. She stated, "you know, again, probably a little anger, that I'm saying as a professional I'm closing services and getting pushback on that." Once again, the notion of being dismissed or not having a professional opinion fully recognized and accepted is present in this case. She felt as if her time on the case was

done and the fact that others who had less information as she had and with her reasoning questioned made her angry.

Feeling shock. Another common internal reaction to conflict was shock. Julia described a conflict she had with the FCM on a case where she felt like supervised visits were ready to go to visits with "pop-ins" where a member of the team will drop by unannounced during the visit and observe it for some time. She stated the FCM disagreed with that recommendation when she first presented it in a team meeting. When Julia arrived at the next court date for the case, the FCM asked the judge to remove her from the case because she was too biased in favor of her client. Julia was completely blindsided and described her reaction this way,

> I mean, that exact moment, I'm pretty sure it's like a cartoon and my mouth fell to the floor – I'm usually really good in court and can control my facial expressions – huh-uh – that one took me completely by surprise! And it was just like pure shock and I was just like ok, all right – I kind-of looked over at my supervisor and we just kind-of looked at each other and then it was over, you know? We walked out and it was just like this complete shock of seriously?

This quote highlights once again that conflicts can arise in multiple settings. Exploring the quotation also demonstrates the importance of communication. This conflict originated in a team meeting where Julia made a recommendation that the FCM and the FCM's supervisor did not agree with. That in and of itself is not unusual, in fact is a common occurrence that all participants discussed. What makes this situation unique and shocking to Julia is how the FCM decided to proceed once that initial recommendation was made. According to Julia, the FCM never really approached her to provide reasons for disagreeing with her or what could happen for the FCM to agree with Julia. There was

no communication and then the FCM just asked for her to be removed from the case, which ultimately lead to Julia feeling so shocked.

Participants feeling shocked was not limited to the case decisions of team members but also how they acted as conflict unfolded. Lily was shocked when a team member she had previously worked with was combative toward her client to the point that Lily had to regularly help her client to calm down after having interactions with this team member. She remembered the shock she felt with some of their interaction stating,

> I remember being like, 'what the what?' 'What is this guy doing?'… I had worked on a case with him previously and he was awesome, so I was really surprised when this tension bubbled up so quickly because I was like, 'what happened?

Tabitha experienced shock in a similar way and put it simply saying, "I'm just like are you kidding me? Is this how you talk to people" when she described her internal initial reaction.

Feeling uncomfortable. Participants also used different words to describe their overall initial reactions that included feeling uncomfortable due to feelings of stress, anxiety, and nervousness. Monica was extremely descriptive as she explained how she felt in a team meeting where members representing the two different parents looked to her to weigh in on how to do proceed. She recounted her reaction this way,

> I would term it as like nausea-inducing anxiety. That's my term. I mean, just like very uncomfortable when people are in that level of conflict and asking something directly of you while, you know, tensions are that high, it's very uncomfortable.

Being this uncomfortable led some participants to state that they dreaded going to certain team members or that they had to mentally and physically prepare themselves before some meetings. They even found themselves using the same coping skills such as

deep breathing, which they teach their clients. Despite this feeling, home-based therapists still need to be able to confront conflict and address it. They chose to not let their negative feelings dictate their actions because they know that just avoiding conflict for their own comfort would cause their clients to suffer and lose trust in them. Tabitha highlights this point as she described how she handles being uncomfortable when conflict arises,

> I do a couple of deep breathing techniques because it's like I'm not comfortable, but I also have to lean into the pressure at the same time because I can't fear it, you know, because my client needs me to be strong because I need my client to be strong. So I need to make sure that I'm able to be that support for my client and I recognize that this isn't about me,! and this isn't about my convenience and…yeah. So it's just like ok, here we go!

This quotation also shows how the internal reaction is just a small part of experiencing and addressing conflict as Tabitha quickly responded internally and transitioned to thinking about her client and what she needs to do next.

Feeling attacked. Finally, feeling attacked or becoming defensive can also be an initial reaction experience by home-based therapist when conflict emerges. Those who expressed these reactions also made it a point to note that they tried not to succumb to these feelings and tried to remain professional and focused for their clients, again highlighting the internal response to the initial reaction. Melissa, who was only 4 months into the profession at the time of our interview, seemed to have an even stronger initial reaction as she reported feeling vulnerable when conflict emerged due to her lack of experience. Maria had a similar experience when the team began to use her age to question her actions, recommendations, and overall qualifications which then became a source of conflict. This caused her to begin to doubt herself, as she stated, "I had second

doubted myself a little bit, oh, am I really too young to be doing this?" Others even said they at times have felt hurt when conflict emerges based on their work with clients. Just as there are many sources and types of conflicts there are many reactions a therapist can have and again, it is important to explore these reactions because they can then influence the therapist during the decision process.

Thoughts. Emerging conflicts did not only cause emotional reactions as many participants discussed internal thoughts that accompanied their feelings. While some discussed how the emergence of a conflict caused them to think about their own qualifications and actions, others discussed have those same questions but about their fellow professionals on the team.

Doubting self. Participants also experienced thoughts of self-doubt. This included doubting their own actions like Sarah expressed when she described how she reacted after a conflictual team meeting, "I just started thinking that maybe I shouldn't have opened my big mouth and said anything at all…or said it differently, said it a different way." There were also thoughts of doubt about their own abilities or qualifications. Maria experienced conflict due to a client questioning her qualifications because of her young age and some members considering that a possibility and perhaps removing her from the case. Maria described her thoughts when this first was presented, "I had second doubted myself a little bit, oh, am I really too young to be doing this, yeah, so that was one of the thoughts."

Doubting team. Participants also had initial thoughts about their fellow team members. Some questioned team members qualifications, attitude towards their client, or level of engagement/motivation. Tabitha felt that a GAL on her case was being

unrealistic and was out of touch a little bit by making so many demands of her client as they struggled with substance abuse. She shared her initial thoughts as the GAL demands started to become a problem, “they are so unaware of the true struggle and the true reality of the client’s situation, they are so far removed that they don’t even understand what they’re asking, it’s completely unrealistic. That was my thought.” Maria had a similar thought in response to finding herself in conflict with her team over how to best approach her client stating that “I’m thinking, ‘well, I don’t think they understand what she’s really going through.’”

Making a Decision

Weighing pros and cons. Once the home-based therapist processes their initial reactions, they must make a decision. This is the stage where a cost-benefit analysis becomes pivotal. When deciding how to move forward, home-based therapists weigh the pros and cons of different actions they could take. Some participants described this process as a rather quick, internal, and seamless endeavor. These participants tended to have more practice experience. Newer home-based therapists also described their decision-making process, but they often needed more time to consider their options and involved peers or supervisors in their thought process. More experienced therapists did this as well, but this was usually reserved for more complicated cases.

When engaging in this cost-benefit analysis, participants did so with three guiding factors in mind. The most common factor guiding participants was the client. This was followed by the therapists thinking of themselves and their agency. Participants take their role of therapist and advocate seriously and as a result they did not want their actions to hurt the client, slow down their progress, or be used against them in any way. This fear of

hurting the client guided participants in not only what action to take but in the manner in which to do it. A common question the therapists would ask themselves was about what they could share versus what they should be vague about. They wanted to keep what was discussed in their sessions with the client confidential as best they could but also knew that team members may be making uniformed decisions if they did not share the information they had.

Sarah had a case where the team felt that the mother favored her older child over the youngest to the point where they even questioned if the mother even loved her younger child. This became a bigger issue as the team contemplated reunification after the mother still showed favoritism in visits despite being confronted about it by the team. Sarah was working with the mother and knew that her reluctance to interact with her youngest child did not come from not loving her but from being unsure of how to address her problematic behavior and diagnosis and even at times afraid to do anything to upset her. They discussed this at length in therapy as well as the mother's reluctance to admit the fact that her child scared her. When the team doubted this mother's love, Sarah struggled with just how to inform the team of this additional information that only she possessed stating,

> I'm trying to think in my mind how can I share with the team that she does – other than to tell them, you know, she does love her – both of her children and them understand it…without them just pushing it off like yeah, whatever, because they have said that before and it's like, ok…I struggled with that in my mind – I kept thinking well, they don't have the full story, they don't see everything that I see. I don't see everything either, but I see another side of things that they don't, so I felt like it was hard for me to share some of that, too, because of confidentiality and just trying to figure out what makes sense to share, what can't I share.

Considering if and how to share information can also depend on who is in the meeting at the time. Participants spoke about being mindful of how information could be used against their clients by both other family members in the room and also other professionals, especially those who already had a negative view of their client. Edward noted this when referring to a case with an FCM that he felt had a negative bias towards his client stating that,

> When you have someone come in and say like 'all of this is garbage, this family is terrible, we're never moving to reunification – like, I don't think I will ever be able to like agree with the team that a kid should go home' – that makes it a lot harder for other people to voice their concerns.

Edward even recounted a time when the FCM was actually voicing legitimate concerns and Edward had some of his own but he still questioned if he should share them because they were minor and he feared the FCM would just add them to his list and blow them out of proportion. Lily also described a reluctance to share even minor concerns or issues "because I felt like any ammunition for the other side was gonna tank my client." This is a very combative way to look at her team and she admitted as such and stated that she did not like operating this way but felt it necessary to help her client and keep things "balanced."

While the participants in the meetings are an important consideration in deciding to speak up or not when presented with a conflict, so is the subject matter itself. Julia provided a good example of her process stating,

> I think it was me kind-of constantly weighing the consequences of whether to say something in that moment. Like, ok, is this a big enough deal – is it going to impact the family long-term or should I just let this one slide? Because, I mean, as far as like playing dumb, yeah, I can do that, but if it's really significant to the family or I believe it's truly unethical or whatever, I'm gonna say something, even if that means getting in trouble.

Certain disagreements may not be significant enough and, again, there is a notion of choosing one's battles carefully when confronted with a conflict. Here it is clear that Julia uses both what the family or her client wants as well as her professional code of ethics to help guide her in the decision-making process, not what would be convenient to her.

There is also a balance between serving the client and being part of the team that is important to consider for some participants. Dave said it well when he described his internal process on what to do when conflict emerges,

> When I'm there I'm thinking first of all, from just a – like a camaraderie standpoint – if I say this, what will happen next? What will happen next? If I don't say this, what will happen next? So, thinking from a stance of comradery with the team and with the clients – if I say this, would it upset this person or upset that person or how this person will react or what would be said?

Clearly, Dave is weighing his options and will make a very deliberate and thought-out decision. He has thought about his options and possible reactions and outcomes to those options and is preparing to move forward.

In addition to thinking about their client when weighing what to do about the presenting conflict, participants also considered themselves and their agencies in their decision-making process. No one wanted to be seen as difficult to work with and did think of their reputation and that of their agency. Julia spoke honestly about the unique relationship between her agency and the Department of Child Services (DCS). What makes this relationship so unique is that her agency depends on referrals from DCS to maintain their funding. As a result, disagreeing with DCS recommendations can be a sensitive matter as there is a power imbalance which many home-based therapists stated had in impact on not only if they would confront an FCM but how as well. Julia touched

on this when describing how she decided to operate when she had conflict with the FCM employed by DCS,

> Our agency only survives by getting referrals from DCS, so the biggest thing is maintaining those relationships in order to still have – I mean – business essentially is what it is, you know? To be able to take those cases and make the agency money that pays my salary, so…and while she's only one FCM in an office of 30, her supervisor has ten of those FCMs and if her supervisor is also unhappy, that means we've lost 1/3 of the people who could send referrals to us. Plus, I mean, every office talks, so if suddenly our agency is on the blacklist, then we're not getting referrals.

She knew that her actions not only reflected on her but also her entire agency and she acknowledged that was a big responsibility and played into how she conducted herself within the team, especially with the FCM. Kim, who worked for the same agency echoed this stating that she did not want to upset the FCM. When asked why she was afraid of upsetting FCMs, she bluntly stated, "they won't send me anymore clients." This speaks to the delicate balance of not upsetting those who are in charge of sending out referrals and thus have a large impact on the funding of agencies and ultimately the employment of home-based therapists.

Emily had a similar thought process in recognizing the hierarchy that ultimately exists on the team with DCS having the ability to refer services from specific providers and change providers, as well. This seemed to be in the back of her mind as she questioned how to address conflicts stating,

> I know the order of – the power – I only have so much power in a situation, so…you know, DCS is in charge – I will challenge it to a certain extent, but if they are like, no, I'm not going to overstep my boundaries because I know that's going to be detrimental to the case.

She is willing to challenge DCS to an extent but is also aware of when enough is enough because in the end, she wants the case to continue progressing and wants to continue to

help her client. Again, it would appear that she is able to recognize which situations are worth fighting for and which ones may be a losing battle and uses this to guide her decision in how to act when faced with conflict.

When Dave was asked about his decision-making process, he outlined a long list of questions he asks himself that guide his decision. The first thing he does is gauge importance of the situation by asking himself

> Ok, how important is it the thing I have to say on a scale of 1 to 10? Is it one word – nah, it's not even that important to say at all or is it 10 where it's oh, this needs to be said right now during this meeting. Then after I evaluate how important it is to me to say that, I evaluate how important it is to the client for me to say that.

Next, he evaluates if this is something that the entire team should hear. Finally, he considers his own comfort level with confronting the conflict. Here, it is clear that Dave, though new and still not completely comfortable in all matters, knows that his comfort level has to a backseat to the needs of the client.

> So, after I've gone through all of that and I've kind-of gauged my own feelings, like am I comfortable with this? Usually the answer is no, but is it something that I need to do regardless if I feel uncomfortable or not? Sometimes it's yes, sometimes it's yeah – you're gonna have to do this right now, you're not gonna like it, you're gonna be put on the spot and you're gonna have a great time and try to explain it on the fly and everyone looking at you. Sometimes I'm like no, I feel really confident and this is what needs to be said and this is what I'm going to say and if you don't like it, that's too bad, because this is what needs to happen.

Now that Dave has gone through his checklist and his options, he is ready to respond to the conflict and has chosen the response that he feels is best for this particular case, with this particular team, at this particular time.

Bringing in ethics. Ethics can also be a major contributing factor to deciding how to address conflict. Melissa spoke about an ethical obligation she had as a therapist to address conflict.

> I mean, ideally, everyone involved in DCS, the ultimate objective is the well-being of children, but there's still…needs that could be addressed for parents, even if they're not fit parents – we still need to be engaging in services and helping them while they're involved with the system…and if we're not setting that supportive tone and saying you're welcome at this table, then we aren't doing our jobs effectively – we're not doing it ethically…where we have to negotiate these kinds of conflicts of interest in a way that is respecting everyone's values and rights and values of the person…and if that's not happening at these kinds of meetings, I have an obligation to speak up.

There are certain factors or team dynamics that warrant speaking up and Melissa uses her professional ethical principles to help guide her decision-making process. She stated that she "had to speak up at that moment" and "felt an obligation to speak up at that time and kind-of advocate" for the client.

Monica also used professional ethics to guide her process when she refused to go along with the rest of the team and the mother in the case because she did not feel it was the right decision. The team wanted to increase the mother's visits with Monica's client, but Monica felt the mother was still acting inappropriately as she attempted to parent her child in the visits and still had unrealistic and age-inappropriate expectations of her child. The team even tried to steer her away from saying anything, stating that the mother would not want her around anymore after she made a recommendation against her. This did not seem to factor into Monica's decision-making process as she stated, "I have to do what I think is ethical and right whether or not mom wants a relationship with me after I attend this meeting – like I still have to do what I think is right."

Responding to Conflict (Action)

Once the home-based therapist has had the proper time to decide how they will respond to the conflict, it is time to implement the response they think is best. They have contemplated what to do in their minds and perhaps staffed it with supervisors and/or coworkers and are now ready to carry out their plan. This plan is what they think is best for their client after considering what the client wants and how the team may react. Three different options emerged from the interviews: letting it go, waiting and seeing, and acting.

Letting it go. Letting the conflict go without an argument or resistance can occur in several different ways. This is where the cost-benefit analysis can be a deciding factor. One reason for using this approach that emerge from the data is that the issue and resulting conflict is just not that important. Maria spoke about a conflict that emerged early on in a case at the same time as several other issues that needed to be addressed where the team actually agreed on what to do. She opted to prioritize some issues over others and made a conscious effort not to appear too demanding with the team in the beginning. She feared if she made too many demands in the beginning, the team would start to get annoyed with her and not listen to her later on when perhaps the stakes or the issues were larger. This idea was echoed by several other participants who stressed the importance of choosing their battles strategically when needed.

Tabitha also talked about several team meetings where she made conscious efforts not to engage in conflicts that were emerging and becoming unproductive in her opinion. She stated this was her preferred method because

> I think that there are times when it's your role to not say anything, just because I mean, there are times there are arguments that you just – it's

> better to not engage in, because what they're arguing about isn't really worth it and it's not gonna come to a viable solution and I'm really solutions-focused in that way – I'm like ok, what can I get out of this?

Rather than engage in a back-and-forth with the other professionals, she opted to not engage and ultimately waited to speak until the conversation was more open and productive.

While letting a conflict go is sometimes a calculated choice, there were instances where participants described it as more of a passive approach to conflict. Allison was removed from a case against her will through an email chain in which, by the time she saw it, it was already decided that she would no longer be working with her client. She accepted it without a fight, thinking there was nothing she could do at that point though she still felt like she did nothing wrong and was making good progress with her client. Ben described a situation he found himself in during a providers meeting where people were ganging up on the mother who was not there and speaking very negatively of her. He recalled how he felt it was inappropriate and how he let it go, something he has done in the past in similar situations, "For me, I usually just – I'm shocked and sometimes I don't even know what to say…I'm probably pretty passive in those situations…I don't get on that bandwagon…but I don't necessarily stop it like I probably should either."

Emily has a situation where she was working with the mother whose children were staying with her sister. The aunt in this case wanted to adopt the children and Emily felt like because of this, there was a part of her that didn't want her sister to succeed and saw Emily as a threat. Eventually, the aunt requested Emily be removed from the case for reasons that were untrue and DCS never asked Emily about. Emily wanted to fight this because she was making good progress with her client, but she had just gotten a new

supervisor at her agency who just went along with it. Emily was frustrated when comparing her two supervisors stating,

> I loved my old supervisor because she would always advocate for whatever was the right thing to do and when I had the new supervisor and she was just kind-of passive, I was just like really? You're not gonna fight it at all or say anything? But – so that was hard to accept.

Emily's case is interesting because it shows that the therapist does not operate inside of a vacuum and can be forced to take an approach they would not otherwise have taken on their own. Emily did not want to use the letting it go approach, she wanted to remain on the case and was ready to confront the conflict. She wanted to tell the FCM about the false statements the aunt was making about her and her work with the client. She wanted to tell the FCM about the progress the client was making with her, but she could not because she did not have the support of her supervisor who had gotten involved. This new supervisor did not want to upset the agency's relationship with DCS, so she simply reassigned the case to another therapist within in the agency. This also highlights the layered relationship between DCS and referral agencies that has already been explored.

Waiting and seeing. Similar to letting it go, the second response to conflict is to wait and see. Here the therapists are monitoring the conflict to determine if there is a point where they need to step in and confront it or think it might be better to just ride it out. Participants talked about selecting this course of action as a result of the actions or more often inactions of a team member, usually the FCM. Other times it may be due to the complicated nature of the case itself or it may be a timing issue. The possible reason behind this approach is that the home-based therapist is waiting for a team member to do what the therapist considers to be the right thing. They may be concerned but either it has

not reached a level where they feel like they have to go against the team and address it or they feel like they do not have enough information, evidence, or support to convince the team that they are right.

Lily had some issues with an FCM whom she felt was unfairly treating her client. She stated that it was even evident in the FCM's communication with her client, as she either would not greet her at team members or would do so with a negative tone while all other members got a much cheerier disposition. The fact that the client also picked up on this and it caused her anxiety and frustration was very upsetting to Lily. She described her struggle about whether to say something or not in her interview stating,

> I was at staffing recently, I'm like, should I say something to her [FCM] about it? Ultimately, we decided I should just let it ride because saying something may just make her more defensive and whatever, so that hasn't been resolved yet.

If Lily felt like the FCM would be more receptive, perhaps she would have said something to her. Lily's thought process, and that of her colleagues who advised at the staff meeting, again shows the importance of utilizing a cost-benefit analysis approach. The fear of things getting worse or perhaps retribution far outweighed the negative comments and tone her client was subjected to during team meetings. This also highlights the power imbalance as Lily believes the FCM has the power to make the situation worse for her client. She also feared that the FCM may not be as receptive to referring to services or siding with the client on decisions if Lily upset here by confronting her on this matter. With this in the back of her mind, Lily decided to let it go at that time, but she stated if the behavior continues to be problematic or gets worse, she might be forced to act.

Participants also discussed waiting to see if FCMs were going to take charge of meetings or provide more guidance on cases. Participants felt like it was part of the FCM's responsibility and role within in the team. Ben talked about a time he utilized the wait and see approach within one of his current cases. In Ben's opinion, the conflict is between the FCM and the rest of the team because the FCM is not really engaged in the case and is not providing clear guidance or expectations, which in turn is making all the providers' work harder because they are left in the dark about what direction to take their work with their clients. In Ben's case, he is actually still waiting to see if the conflict will resolve itself, if it is something he'll just have to accept, or if he will need to say something. He expressed his strategy stating,

> So hoping that the FCM kinda steps up and provides some, you know, some guidance. Ultimately, she's – she's a big part of where things go…so yeah, honestly right now, I'm just trying to figure out kinda what she says in terms of what the plan is gonna be because she was thinking about changing the plan to adoption for reunification, just closing with grandma, but we don't – she doesn't communicate well, so we don't really know and that's a pretty big problem in and of itself, too.

This is an example of a home-based therapist staying in the wait and see mode for quite some time. At the end, Ben also points out the importance of communication and collaboration in this work. This was a theme throughout the interviews. Good collaboration can make progressing through this proposed model much easier and will be explored later in this chapter.

Sarah described what she called an "inner struggle" as she sat in a team meeting that was getting out of hand.

> So – and DCS was running it. In my mind, I'm thinking DCS needed to rein it in…and I was getting frustrated because they weren't doing that and I kept thinking should I say something? But then I was thinking it's not my place – this is a DCS meeting and really, they need to be reining this

> in…so that was an inner struggle – I kept just – my inner thoughts just kept struggling amongst themselves, should I say something, should I not say something because this isn't my place, this is DCS, we're actually meeting at DCS, it's not even my organization meeting, I'm not running the show, who am I to stand up and say something? But it was my client and I'm advocating for her, so my own thoughts were going back and forth, back and forth. Then finally…the DCS FCM did stand up.

Sarah's wait and see approach eventually resulted in the FCM doing what she had to do, perhaps not as quickly as Sarah would have liked, but she was able to maintain her role and allow the FCM to maintain hers as well. Sarah was able to let this particular conflict go, highlighting the fact that the wait and see approach ultimately must lead to one of the other approaches. Ultimately, Sarah was satisfied enough with how the FCM stepped up that she went from waiting and seeing to letting it go. This quotation also demonstrates the participant's strong sense of advocacy and the delicate balance that sometimes exists in MDTs.

Finally, Diana provided an example similar to Ben's but one that has moved past the wait and see stage and into confronting. Again, this conflict revolved around an FCM who was not fulfilling her role and was not getting things done in a timely manner. Diana continually advocated for therapeutic visits but felt that the FCM was dragging her feet for some reason. She also grew frustrated with the CASA and GAL who were not very engaged either. While she waited for each of these team members to act, she, like the others, questioned what to do next and even if she wanted to remain on the case, since she also saw herself as a possible source of conflict and tension. Ultimately, she decided to stay because she felt like she was the only advocate for the children. Next, she describes how she first opted to give the FCM time to do what was right (waiting and seeing) but after that failed, she started confronting the conflict stating,

> So I let probably ten days go by and then I'm emailing the FCM – where are we on these therapeutic visits? Where are we on these therapeutic visits? Went to the point and like found providers that were free to do that in that county and sent her like two or three names of people recommending these are people that can provide therapeutic visits that have openings right now – like I'm trying really hard to do your job for you!

Diana waited long enough in her opinion and the stakes were too high to wait anymore so she opted to act, even if that upset some team members. Again, thinking of the cost-benefit, she felt as if getting the needed services in place was more important than not stepping on anybody's toes or being liked by the FCM.

These examples so far demonstrate how waiting and seeing can ultimately lead to letting it go or confronting. A home-based therapist may also stay with the wait and see approach for an extended period of time as they question what the best course of action is or monitor the situation carefully for any signs of improvement or deterioration. These examples also highlight the fact that conflict can occur in different venues and can be addressed using different methods such as face-to-face conversation or through emails like Diana used.

Maria provided an example which demonstrates the way a therapist might wait and see based on the progression of the case. She had a situation where she really thought that couples counseling would be beneficial for her client and her client's husband. She was already provided therapeutic supervised visits so she saw firsthand that the couple could benefit from further services. However, when she presented her recommendation to the team, they did not agree. She did not push the issue though, opting instead to just let it go. When I asked her thought process in making this decision she stated,

> In that moment, it was – so it was pretty early on in the case – that team meeting – and so I'm like, ok, I might just need to give it some time and

> see what goes on…and then in the meantime I can still work on some things in supervised visits.

This is another example showing how the wait and see approach ultimately leads to either action or letting it go. In this particular case, Maria opted to for letting it go, as a she stated "I did let it go in that team meeting…yeah. Yeah, they were doing their supervised visits, I did let it go." Ultimately the fact that she was able to work around the conflict and still get her way made it easy to let go of the recommendation that the couple engage in formal couples counseling.

This is also a great example of a therapist thinking both in the long-term and short-term and using them to guide their actions. In the short-term, Maria knew she could incorporate some of the skills she would present in couples counseling during the visits she supervised. In the long-term, she knew she might need to take a stronger stance for a recommendation and if the couple's relationship got worse, she might need to advocate for couples counseling again, only with more force this time. To give her the best chance of being heard with open minds from her fellow professionals on the team she wanted to cultivate some positive relationships with the team in the beginning in the hopes that it would help with any potential future conflicts.

Confronting. If a home-based therapist has decided that the conflict is too significant to be ignored and monitoring is not a safe option, then they will utilize the third response to conflict, confronting it. This decision can come directly from the emergence of the conflict or it may come after some time, as perhaps the therapist first opted for a wait and see approach but now, they need to confront it. Participants discussed two different ways they confront conflict with other professionals on their teams. One approach is an in real time response, while the other is retroactive. Both use

similar techniques which will be examined individually below. However, these approaches differ in their timing and sometimes in their means of communication depending on which approach is used by the home-based therapist.

Choosing when to confront. After examining the data there appears to be two deciding factors that can contribute to which approach the therapist will ultimately take: comfort and audience. Participants who were less comfortable with either the subject matter of the conflict or conflict itself, opted to respond to the conflict after team meetings. Similarly, those who had concerns about how certain people would respond to what they had to say about the conflict also waited until after to reach out to those members whom they felt needed to hear what they had to say.

As was discussed earlier, who is present at the meeting is a contributing factor in the decision-making process for home-based therapists. They carefully consider what they are going to say, who needs to hear it, and perhaps more importantly, who should not hear it. Timing is also an important consideration as Edward pointed out in his example of not addressing a conflict right in the moment. At this team meeting Edward's client was not present and the CASA had just been complaining about how manipulative she was and other reasons for his desire to suspend visits with her children. Edward described his struggle with how to address what he saw as an inaccurate assessment and disproportional recommendation.

> So I tried to kind-of strike a balance where like my impulse is to be defensive for my client, I think…but I recognize that he wasn't in a place to hear that, especially when he opens by telling me that she's manipulative – if I start defending her, he's probably going to read that as like she's got her hooks in me or whatever.

The attitude of the CASA caused Edward to respond retroactively a couple days later when he met with the CASA prior to the case's court hearing to ask him more questions about his concerns and tell him what he saw in visits and his therapy with his client. Edward stated he was very pleased with that conversation and felt like both sides were able to understand each other better after this conversation.

Dave told of an instance that happen just the day before our interview where both his comfort level and the participants of the meeting resulted in him not saying anything in the meeting. Though he did not say anything the day before in the meeting he was now wanting to email the FCM to voice his opinion and ask more clarifying questions. Dave, who graduated with his master's degree six months before our interview, spoke throughout our interview of being new to the position and trying to work on being more assertive, stating "I'm a little new, so for me I need to learn how to be a little more assertive in these meetings." He referenced the speed of the meetings as a factor that will sometimes result in him not knowing what to say in the moment. In this particular case he found out at the meeting that DCS would be recommending that visits go from unsupervised visits with pop-ins to overnight visits with no pop-ins. He felt unprepared to make an argument for slowing down this progression stating, "I figured it out at the meeting that was the recommendation. That…that's what was gonna happen. So my reaction to that was I was little shocked for a second, I was like, ooo, I don't know what's going on."

To further complicate matters, the client's parents were at the meeting and Dave was concerned about how they would respond to his recommendation to slow the visits down, something that obviously went against the wishes of their son. Dave explained his

concern stating, “so with client’s parents there, they’re very overbearing…they also are – they can be really sassy…they are really sarcastic with services and they kind-of puff up their chest when things don’t go their way.”

This combination of being blindsided by this recommendation and being concerned that his opposition would be unwelcomed and perhaps take focus away from his concerns due to the presence of the client’s parents, who did not have a direct stake in the case as they were there solely for moral support of their son, Dave’s client, caused him to remain quiet about this topic during the meeting. He still had concerns though as the client had just admitted to him about spanking his children during a visit. He laid out his plan on how he will address this stating,

> but I want to email the FCM today and I’m gonna be like, ‘hey, yesterday at the meeting, I thought about this a little bit, I want to have some time to think…we kind-of recommended pop-ins, what made you choose doing overnight unsupervised visits instead of pop-ins?’ and ask about it because I felt like at the meeting she also had to leave right away so I didn’t have time to talk, but I had a quick 10 minutes to tell what was going on in therapy, but I really want to go and give more time to this topic because I think it’s something I think that warrants a little bit more conversation.

Clearly, Dave did not feel like he had the time to make a decision during the team meeting. He also did not feel like he had the support or the appropriate environment to even discuss the matter to the extent he felt was necessary during the team meeting. He was not comfortable voicing his concerns on the fly which is essentially what he had to do since he was unaware of the recommendation that DCS presented in the meeting.

Tabitha focused on facts and discussed how she knows whether to respond in the meeting or perhaps wait until she had time to gather facts, stating,

> if they are arguing about something that I have factual knowledge of and can advocate for, then I make the decision in that regard and if I hear them saying false information about a thing and I have the facts to back up what

> I'm talking about, then I speak on that…if I don't, if I'm like – if what I know is just – if I'm not totally confident or something like that or if I think it's a possibility or whatever that case may be, then I don't invest in it [speaking up in meeting]… My approach is like that because I think that I have been really dead wrong and embarrassed at given points trying to advocate for people and I wasn't sure about myself and I wasn't – and then people will call you out and demolish you.

Because of past issues, Tabitha has now adopted a pragmatic approach of not saying something she is unsure of. This was true in the case she discussed, as she did not provide pushback to certain members until after she was able to do some research on her own and come back to them with some facts.

Being comfortable enough to respond in real time as opposed to retroactively also requires that therapists to be knowledgeable about what is being asked of them. For those who utilized the retroactive approach, they may be uncomfortable making recommendations in the actual meeting because they may need to research a diagnosis, the effectiveness of a treatment modality, or they may simply need to spend more time with the client in order to have an educated opinion.

Those therapists who were prepared for the conflict, comfortable with conflict, and more confident in their arguments, were much more likely to address it during the team meeting. Even Dave, who spoke about needing to be more assertive talked about a time when a meeting was called for the sole purpose of discussing a conflictual issue. He did his prep work beforehand (getting feedback from supervisors and peers), was prepared to discuss the issue, and did so during the meeting. Some of this comfort level also may relate to the personality of the therapist. Those who talked about addressing conflict retroactively were also those who stated they tend to be conflict avoidant.

Choosing how to confront. Regardless of which approach a therapist chooses, they will have to communicate their opinions to a specific individual or individuals on the team or to the entire team. For those responding retroactively, they may do this through email, phone conversations, or in person after the fact. Those responding in real time will respond to the conflict in the manner that it emerged, usually in person at a team meeting, but this could also occur during a phone conversation or even an email if the therapist responds to the email right after reading as opposed to waiting a day or two to perhaps gather their thoughts or craft a nicely worded response. Independent of the response type, participants discussed several common approaches or strategies they use when addressing or confronting conflict with other professionals on their MDTs.

One aspect that all participants mentioned in one form or another was how they were mindful of their language and tone when addressing conflict with other professionals. They did not want to come across as biased towards their clients or too forceful or disrespectful towards the other professionals on the team. Participants used words like “careful”, “gentle”, and “PC” to describe the way they conducted themselves when confronting or challenging team members who had opposing views of them on certain issues.

Part of home-based therapists choosing their words and their tone carefully is knowing how to best approach members of their teams. This helps to ensure that team members hear what the therapists want them to hear and nothing gets lost because someone become defensive or upset. They must be able to read people to determine ways to effectively communicate with them. Emily prided herself on her ability to change communication styles if need be stating,

> I'm very good in communicating things in a way that makes sense to people and I just go with however the person's personality – you know, I just go – my approach is totally catered to the individual I'm trying to talk to…so it's – I change it up all the time, and it's helpful, it really is helpful

Adam discussed this as well and described how he judges if he can use his preferred method of being direct with people or if someone needs a softer or more indirect approach of communicating,

> Usually if I can be direct with somebody, I can tell because when I talk to them, they speak to me directly. Typically if I speak to someone and they always seem to have some sort of weird excuse about something or they're not very clear in their speech, they're very broad and hazy – like they use very unclear terms when they're talking – that always sort of clues me into whether this person can be direct or not or accept a direct conversation.

This is something that came naturally to most participants who talked about it but it was still a conscious effort and for some it was clear that it was tiring. Julia talked about certain cases where she needed to be more mindful than others. She also talked about adjusting her approach after other conflicts perhaps shifted the dynamics of the group or showed certain members to be more sensitive than she had suspected. She talked about one case in particular with a new FCM where she felt her interactions change after she tried to inform the FCM how certain services work during their first meeting. She stated,

> So not only do I have to like always be thinking about how I'm talking to families and working with them because you are always thinking about rapport and how you're doing that – now I have to constantly be thinking about how I'm communicating with this particular FCM

Julia continued to discuss how she changed her language and her tone not to upset the FCM or have her take anything personally.

> Yeah, I made a conscious effort. I was sitting there thinking like if there's something I disagreed with, you know, how I was going to state that differently so that I wouldn't offend her, so I would be really conscious

> about talking just about the family and the family's progress towards their goals and what maybe they needed to continue in order to reach those goals, like just be really specific about that language – making it all about the family, nothing to do with DCS or their services…really trying to keep the focus and then – this is gonna sound bad, but my supervisor told me…just play dumb sometimes – like yeah, you might know the answer about the services and things they say, but let her figure it out. She got upset because we tried to tell her how services were and things like that, so unless it's a direct question about it, just don't offer extra information, like that was kind-of the approach I guess I had to take. Whether that's right or wrong, I'm not sure.

Participants were also concerned with sounding biased for fear that team members would not fully listen to their recommendations. One approach that participants used to ensure they were not coming off as biased was only to use facts to make their arguments. This is what Kim did when she found herself advocating for a different placement plan than the majority of the team. She came prepared to the team meeting to make her case based on the facts presented in previous monthly reports stating,

> I had a couple of monthly reports so I brought all of that with me to the meeting and it was like they're not – you can see some of the things they're saying, they're not getting anywhere, and I think there's enough safety concerns in the home that we really need to talk about placement for this child not in the home…so they did agree with me…once I presented all of that.

Her preparedness paid off too as she was able to convince the team to agree with her. This may not have happened if she had not been organized and able to point to specific, document concerns.

To avoid being too aggressive and being perceived as being disrespectful, participants made a conscious effort to keep their emotions in check and not take any conflict they encountered as a personal attack on them. Destiny described her approach like this, "So I try to watch myself. I try to make sure my emotions don't take the front seat and drive the car, you know?" This is something Adam expressed as well when he

described a conflict that he had with a CASA who was questioning if Adam was doing enough therapy based on some inconsistent reporting about the client's mental state. Adam at first was upset because it seemed the CASA could not keep the facts of what the client actually stated straight but quickly calmed down describing his initial response as having "a little bit of how dare she, you know? I don't know – there was a little bit of that, but, you know, I combed that back down and was like wait a minute, let's think more…more balanced about this." Once he did this, he was able to express himself appropriately and provide some education on his therapy and his observations of the child.

Another interesting technique that participants discussed was the idea of using therapeutic skills they often use with clients with their professional peers on the team as well. Victoria summed up this approach nicely as she discussed using it with the FCM on one of her cases,

> If there's anything that home-based therapy prepares you for, is to deal with resistant clients…that is the hardest part of the job – is that association and being put in therapy when they don't necessarily want therapy. It's so different from somebody who comes to you and says I need help. So you're always having to tease them – to break down some of that resistance and if you don't get anywhere then you don't really get any work done, so…hopefully I would utilize some of those same skills with the FCMs – without them knowing it.

Some of the skills that participants discussed using were active listening, validating feelings, de-escalating tensions, and clarifying, both by asking team members questions and providing education when need be. Emily even called it a "duty" to intervene and use therapeutic skills when needed in contentious team meetings since she has the training and skills to do so.

Participants spoke about the importance of perception when addressing conflict and the importance of having other members on the team having a favorable view of them, even if they disagree with them. Part of that comes from making everyone feel heard and understood, even if there are disagreements. Emily put is simply this way stating, “I just reach out, communicate, hear them out, validate them even if I don’t agree with their recommendation or whatever.” It is important to note that participants talked about using this approach during the conflict but also throughout the entirety of the team working together. Building on a professional relationship where respect and trust are key factors was important to participants to help their work. This speaks to the need for interpersonal skills and the power of collaboration, which will be examined in more detail later.

The idea of preparing for conflict also was a preemptive approach that some participants utilized. This was a possible approach when participants new that the conflict was going to be addressed in the team meeting due to the FCM mentioning it or the client stating they wanted to discuss the conflict. This knowledge helped the participants get in the right frame of mind so they could best address the conflict. Proper preparation helped to ensure that participants had both the right information to make appropriate recommendations and also the right frame of mind to maintain a calm and professional manner through the meeting, even as the conflict and tension intensified. Some participants discussed taking detailed notes and reviewing them before meetings where they expected conflict. Others worked on mindfulness and deep breathing to help remain calm and not get too overwhelmed or anxious.

Providing clarification is a therapeutic skill that participants used with clients on a regular basis and transferred well to their interactions with other professional team members as well. Clarification is important because sometimes the entire conflict is really based on a misunderstanding. Two participants provided good examples of this and once everyone had a better understanding, they realized that it was all a misunderstanding and there really was not any conflict. Melissa spoke of a complicated case where the parents, who each had their own therapists, had a separate legal issue that required them to go to criminal court. As the FCM talked about court and what needed to happen before and after the court date, she did not specify which court issue she was referring to (their criminal case and their DCS case). This ended up causing issues because as she talked about keeping services in place until court, she meant the upcoming DCS court date, not the criminal trial in the distant future. This conflict was resolved rather quickly by Melissa asking some clarifying questions. She recalled how she started to get everyone on the same page by interjecting and pointing out the miscommunication. She then went directly to the source of the confusion, the FCM, to gain clarification. She remembered the interaction like this,

> I think a lot of what triggered her was miscommunication and misunderstanding with the FCM and the FCM started getting very worked up and very reactive and defensive…and so I had to kind-of interject finally and say, 'ok, what I'm hearing you say…' and kind-of reflect back both of their positions and 'I'm understanding there's some miscommunication here, so let's clarify what we're really talking about…' so 'FCM, when you're talking about court…what you're actually referring to is the DCS case and not the criminal case, is that correct?' And she's like, 'yes,' and so, 'ok…' and so 'there's no reason to keep services in the home that's related to the criminal case, correct?' 'Yes, correct.' 'Ok, so what I think the client is hearing is that you're keeping DCS involvement related to this other outside case…and…her concerns are maybe that you're just keeping the case open because it's easier for you and is that correct?' 'Yes.' And so I said, 'ok, so I'm still closing out therapy

> services, it's not ethical for me to keep going anymore, but there are actually not any services in place anymore, she doesn't have to do anything between now and the next court date – we're all out of her life, this is just a legal issue, correct?' And she said, 'yes.' And so I had to kind-of take that approach with the client where I was clarifying – again – what I hoped the FCM would say.

That clarification was necessary to ensure that the team could have a discussion on terminating services with everyone knowing the proposed end date. Up to this point there was a great deal of pushback from providers who were unsure of the plan. Also, evident in this quote is the use of ethics to justify a decision as Melissa makes it clear that she had reached a point with her client that it was actually not ethical to remain as her service provider because there were no more services left to offer. The client had achieved all her goals with Melissa. Several participants used this approach as a means of justification. This is a particularly strong justification if used correctly because team members will not argue with professional ethics.

Edward also provided an example where clarification was needed. In his example the clarification also led to him using another therapeutic skill of providing education. In his case the conflict was between the team and a CASA about what services to put in place as the CASA was the only one recommending going from supervised visits to the more intense therapeutic visits. This case was discussed earlier with Edward waiting until a meeting at the courthouse to address the conflict with the CASA. Prior to this, at a team meeting Edward had used the wait and see approach but now in the confronting phase he realized that he needed some clarification. He described his interaction with the CASA this way,

> So part of what that looked like is both the FCM and I explained to him what our understanding of what happens at a visit was and what would happen at a therapeutic visit…because that's not actually what he was

> asking for …and so I asked him what would be his goal out of therapeutic visits and what he said basically was he wanted someone at the table with the family the duration of the visit like interacting with them and I was like, 'oh, that's more like family therapy,' so doing a little education about what services are available.

Once, the team had a better understanding of what the CASA wanted and the CASA had a better understanding of what service he was truly asking for, they were able to have a much more informed and productive discussion. This idea of providing education also relates to an approach of using their expertise which was sometimes used by participants. When using this approach, they would incorporate many of the other approaches already discussed, particularly using careful language.

Another approach that participants described was bringing the focus back to the family or to the progression of the case during conflicts. At times of conflict, teams could lose focus or forget the big picture. Elizabeth described a conflict she had with a GAL over the housing situation of the family. Elizabeth was working with the parents who had met their treatment goals, found employment, remained sober, and found housing for their children. DCS had approved the housing and even though Elizabeth even could admit it was not in the greatest neighborhood, it did meet all state requirements and it was within the family's budget so she knew they would not need to stress about how they could afford rent on a monthly basis. However, the GAL was not pleased with the apartment's size or location for this family and refused to approve it and stated she would be recommending a new place. As they continued to argue about the appropriateness of this housing, Elizabeth attempted to bring the team back to their ultimate goal, reunification. She recounted her interaction with the GAL, "'Our goal is reunification,' I would keep repeating that to her over and over again and she's like, 'well, the kids just

deserve better.' I said, 'the kids deserve to be with their family.'" She would also remind her of the progress the parents had made from living in motels and being homeless to now having an apartment, trying to get her to see the big picture instead of what Elizabeth saw as minor issues with their new housing. Elizabeth believed these issues resulted from the GAL's privilege background.

Dave summarized this approach of keeping the team focused in a simple question of "how do we all get back on the same team?" This points out the fact that they are one team that, ideally, will work together to come up with one plan to best support the family. Reminding everyone of that can help bring the focus away from the conflict and back to the family that all the providers are tasked with serving.

Finally, there was one approach within the theme of confronting that was used as more of a secondary approach, only to be used after others had failed. As a backup or to add more weight to their arguments, some participants would also use their supervisors to support what they had been recommending. An argument could become even stronger when the therapist was able to make a recommendation and then say they would also go to the supervisor, who would then agree with them. That's exactly what Melissa did when she found herself not convincing the team on her own. She recalled how she went back to the team after consulting with her supervisor, "I was in a position where I had to say I've discussed this with my supervisor, then I'm externalizing responsibility up the chain and she says, 'well, I discussed it with my supervisor, and here's what we're looking at.'" However, this approach was only used if the therapist first encounters resistance or trepidation from other members when they initially made their case. Going to the

supervisor was a way to acknowledge other's concerns while also making their own stronger.

Diana felt that she needed the authority her supervisor would bring when she "got nowhere" with her recommendations on a case. After continually trying to get an answer from the FCM about what to do about visitation, she finally got a response. She recalled what the FCM stated and how that impacted her decision to bring in her supervisor,

> The case manager's response was, 'well, I will need to talk to my supervisor about this and staff with my supervisor.' So she then called another team meeting at mom's home. So I brought my supervisor because I was like I'm not getting anywhere, I need backup, I need someone else saying the same thing I'm saying, it's not getting through. At that meeting, it was agreed upon – even by mom – that therapeutic visits needed to take place

By bringing in her supervisor and having her support Diana's original recommendation, everyone on the team was now in agreement with Diana.

Finally, if bringing in their own supervisor does not work, many participants discussed going to the FCM's supervisor. They may start including both supervisor on emails and/or they may ask their supervisor to reach out the FCM's supervisor. This is seen as a way to start getting the FCM to communicate with them or respond to their request. It is not necessarily done to get the FCM to agree with them but simply respond to them or follow through on what they said they were going to do.

Team Reaction

After responding to the conflict, participants experienced several different reactions from the team. Reactions varied based on the way the therapist responded to the conflict. For instance, if a therapist opted to let the conflict go without addressing it, there was virtually no reaction from team members because the team and the conflict itself

were not being challenged, making change unnecessary. The wait and see approach had the same outcome. Ultimately, the participants only perceived a team reaction if there was something to react to, such as the therapist acting out against the conflict in some form. When this occurred, participants were able to recall both positive and negative reactions.

Positive team reactions. Positive team reactions include team members being receptive to what the therapist had to say. Participants appreciated when they felt heard, supported, and respected, even if there was still disagreement. When a team member has this approach, participants talked about how much easier the conversations are and how team members' decisions and recommendations are driven by what is best for the family, as opposed to the conflict. Emily talked about how she confronted a GAL after they disagreed on the children returning to the home. She stated the GAL did not have all the updated information she needed to make this decision and approached her to talked about it, stating "I was like, well, this is what's going on…and she ended up changing her mind so the kids got to go home with mom." When I asked how that conversation went, Emily stated, "It went well… she was receptive to, you know, the progress the girl was making and all that I had to say, and she did change her mind which was positive."

Negative team reactions. Negative team reactions include receiving pushback from team members, team members becoming defensive, and team members ignoring what the therapist has to say or denying that there was a problem. Emily also shared a negative reaction she had when she confronted a CASA about the way she talked to her client as she often put the client down and had a judgmental tone. Emily described the CASA's reaction like this,

> She just – she says, 'well, you know, I feel like I support her.' She just disregards what I say – and she is kind of in denial about how she treats her. She doesn't see it. And she always says, 'my job is to serve in the best interest of the children, so that's my focus – is the children.'

This led to more conversations with the CASA in which Emily took different approaches. This provides a nice example of how a team member's reaction can start a part of this process over again. A conflict emerged about how the CASA talked to Emily's client because it upset the client and Emily deemed it unprofessional and not helpful for the case. She initially was frustrated by it and decided to act by talking to the CASA about it individually. When the CASA did not see her interactions with the client as problematic that led to more frustration from Emily. She then confronted her again, trying to take the more pragmatic approach of just seeing if she could get the CASA to undertake more observations to see the mother's improvement and provide clearer goals or benchmarks for her.

Other participants talked about their case recommendations or concerns being ignored. Allison had a case where she continually expressed concern over rushing reunification because she was working with the children and did not feel like they were ready to return to their parents' care. There were issues of trauma and trust that she believed were not addressed yet. She explained how her concerns were met with by the team,

> There was two case managers at the time…and I remember trying to communicate and talking – it was just kinda like, you know, it doesn't matter how much I explained what was going on or what they [the children] were telling me or looking at notes, it was just kinda like, 'well, this is what the parents are ready for and I know that this is your concern, but they've shown growth.'

She became frustrated because she felt like the team was not looking at this decision from all angles. Allison believed that the team thought since the parents had "checked off some boxes" off the treatment plan, they were now ready, despite all the information she had provided in meetings and monthly reports about the children's concerns.

Perhaps worse than being dismissed or ignored, Monica stated her fellow team members tried to make her feel guilty so she would change her mind and agree with them, stating, "I think that it was not necessarily like very vocal like you need to change your opinion, but what they did was, I feel like, they tried to make me feel guilty about making that recommendation." This conflict was about her recommendation that the child in the case receive more intensive therapy that focused on the trauma he had experienced. The team repeatedly listed all the negative behaviors he exhibited after therapy and how upset his mother was going be with Monica if she made that recommendation at the team meeting. She felt their "guilt tactics" but did not change her mind.

These negative reactions can also lead to a completely new conflict. Several participants discussed conflicts they had where they and a particular team member were on opposite sides of the conflict. Sometimes, when arguing for their respective sides, team members might become too aggressive or confrontational which hurts the professional relationships. Now there is conflict over the case plan and personal conflict between two members. How the team responds can also lead directly to what type of decision is going to be made which will be discussed next.

Team Decision/Result

The culminating stage in this model is the result or the team decision. Though this is called a team decision, and ultimately should be, it is not always the case. Many

participants discussed the power that certain members have on the team, particularly the FCM and GAL, when it comes to being able to make more unilateral decisions. As the conflict comes to this stage, participants shared four possible outcomes. One outcome is that the team agrees with the home-based therapist. Another option is that the team does not agree with the therapist. The third option is that the team is at a standstill and agrees to go to a higher authority which may be a supervisor at DCS or the judge on the case. Finally, outside factors may come into play and resolved the conflict without any effort by the team.

Each of these outcomes will be explored in more detail but it is important to note that this may not be the final stage, especially if a home-based therapist is not satisfied with the result or the process the team took to get to it. Certain team decisions may lead to a completely new conflict in a similar way that certain team reactions can lead to new conflicts. Also, once the team makes a decision, the home-based therapist will have another internal reaction and go through the decision-making process over again, with the choice being heavily influenced by the outcome that just occurred. It is not surprising that certain outcomes yield certain actions. This too will be discussed further as each result outcome will be examined below.

Agreeing with the home-based therapist. There are several different ways the team can side with the home-based therapist. The first way is by far the easiest and cleanest in terms of the client because it involves everyone coming to a compromise. Monica discussed a case where different team members had different opinions on how visitation between the mother and her children should progress. In the end, the team was able to work together for a compromise after assessing all of the facts and sharing

information. Monica recalled, “We were, you know, as a team, able to come to that conclusion – that therapeutic supervised visits were appropriate based on some of the things that she had been saying.” The second way that a team may side with a therapist is with other members still disagreeing but being outvoted. This means that another therapist on the team does not agree with the CASA or GAL but in the end the team, or ultimately the FCM in many cases, choses to go with the home-based therapist’s recommendation.

Disagreeing with the home-based therapist. Just as the team may side with the home-based therapist, there were plenty of examples given by the participants where they were the odd team member out and the team went against what they recommended. When this occurs, it is often the FCM agreeing with those on the other side of the issue against the home-based therapist. Sometimes that means they agree with another therapist, the GAL or CASA, a family member, or they do what they or their supervisor think is best. Diana had an example where that occurred. She was against the recommendation that her clients (two teenage boys) would return to their father’s care with a new, more intensive but short-term service which would replace the existing services that aimed to help the father with his parenting. She felt it was going too fast and that the family had not properly addressed a violent episode that led to a police report being filed. She recalled the reaction she got from the FCM stating, “The FCM said, ‘this is what DCS is saying has to be done.’” That was basically the end of the argument during that team meeting.

Diana did advocate to remain on the case and closely monitored this transition, taking a wait and see approach. Not far into the change in services the children had to be

removed from the home due to their father's violence towards them, something Diana was concerned about. She then said she voiced her concerns in court and the judge agreed with her recommendations and the children were removed from the home. She stated the FCM was very apologetic and worked well with her the rest of the case which ended with the father losing his parental rights. This shows one way that participants may react to their recommendations not being adopted by the team.

Other participants talked about team decisions that went against their professional opinions that they did not fight. Both Allison and Emily were removed from a case against their will and just accepted it although both admitted they wanted to fight it because they felt that they were doing work with their clients. In both of these cases, the FCM sided with parents or kinship care over the therapists. Allison was removed because the father did not like her therapeutic methods with his son as she used puppets that he felt were too young and "babyish" for his son. Emily was removed because of accusations made by the aunt who was providing kinship care on the case. Emily reported that the FCM never asked her for her side of the story but instead decided to remove her to keep the aunt happy and perhaps not have to deal with her. Once removed from the case there was not much they could do, leaving the conflict resolved in one sense for the team. Participants had different opinions though as they felt like many issues were left unaddressed and the team could find themselves in the same situation if the family did not like the new therapist either and in the meantime their clients suffer which is what really frustrated them.

This theme elucidates an interesting dynamic of the home-based therapist often being seen as an expert on the team but still being ignored in some instances or dismissed

due to the wish of the family. This outcome also demonstrates how different results lead to different next steps. When the team rejects the home-based therapist's recommendation, they discussed doing the same three pronged response to conflict that was discussed earlier, though perhaps slightly differently. Allison and Emily were forced to let the conflict go when the team disagreed with them about their future on the case. When a therapist is removed from the case, they cannot argue against that, other than saying they disagree. Ben also provided a variation of letting it go when the team did not follow the recommendation he presented at a team meeting and in court. He did not bring it up again in meetings because he felt that the behavior stayed the same throughout but he did put it in every monthly report he wrote. Diana took a wait and see approach when her team disagreed with her. She got strong pushback when she voiced her disagreement but she felt like the plan would backfire as she waited for that to happen. Finally, a therapist can still confront their conflict with the team but have to either take a new approach or bring in new players such as a supervisor or the judge like Diana did after her wait and see approach resulted in a negative instance of violence and ultimate re-removal as she feared would happen.

Going to higher ups. Child welfare team members do not practice without supervision so there is generally a hierarchy as some members discussed when talking about causes of conflict. However, even those considered to be at the top of the team still have someone with more authority than they have. Thus, at times teams will opt not to a make a decision themselves about the conflict but agree to take to those higher up the supervisory ladder to obtain their opinion. The team is stating that they cannot come to agreement on the opposing recommendation so they will let someone else decide. When

using this approach, the team has two options to go to for their answer: supervisors and judges. Though similar in reasoning and progression, these two options often leave the home-based therapist with a different mindset when their recommendation is not the chosen one.

Going to supervisors. Team members can go to supervisors to break a stalemate. I have already explored home-based therapists going to supervisors to help strengthen their case to the team. They will also do this if they need justification to close their case against the wishes of the GAL or CASA or the FCM and ultimately DCS, who is the referral source. Adam used his supervisor when he and the GAL and the FCM on the case disagreed about whether he should terminate his services for the child in the case. Adam argued that since he was no longer needed therapeutically, he should no longer be involved in the case. The GAL and FCM wanted him to stay on the case longer, for what Adam thought was the sole purpose to be there just in case something were to happen. Adam tried to provide some education on his role and when that didn't work, he reluctantly stated he would go to his supervisor for her opinion and to give his recommendation more authority. He recalled his interaction with the team, "I was like you know, I'm gonna staff this with my supervisor, just to kind-of see where I'm at, but this is my recommendation and sure enough she supported me." He eventually closed the case with support from his supervisor.

However, in the context of actually making a decision this technique is typically used by the FCM with their supervisor acting as a tiebreaker. This approach is usually used after the team cannot agree amongst themselves about what should be done. However, some participants shared examples of FCMs going to supervisors directly,

which lead to other participants becoming annoyed and frustrated with the FCM because they felt like they were escalating matters unnecessarily and going behind their backs. Going to a supervisor this way also denied the team a chance to work out their issue themselves. This usually occurred when there was direct conflict between the FCM and the home-based therapist.

Going to judges. Sometimes the team decision was not to make a decision at all, instead opting to the let the judge decide. This option was used at times when team members disagreed on important decisions and the case had an upcoming court date close enough that everyone was also comfortable waiting until then to have a final decision. Adam described cases where this happens as ones where team members dug into their positions and the team was at a standstill stating,

> I feel like a lot of times it's just – what's the judge gonna say? A lot of times it gets to that point and so that's really the equalizer at that point where all you can do – really, it's almost like trying to tell somebody that their religion's wrong, you know what I mean?

This idea that the judge is an equalizer was found, in one form or another, in all participants who talked about going to judges for decisions. Judges are often seen as impartial and they have the final say on case matters anyways so they are a natural person for teams to use to break a stalemate.

There are even times when a conflict might arise at court and the judges makes a decision without the team planning on them having the final say. Julia described a situation like this where she and other providers were in favor of requesting that visitation start for her client and her spouse, but they found out at court that DCS would be arguing against that. The judge sided with Julia and the other providers who were advocating for this. Julia stated "it was definitely awkward immediately after that court hearing" but

they were able to work through it. As the case progressed and the parents were able to show that they could keep their children safe and be appropriate with them during visitations, the FCM began to support this decision more and team had a more unified stance on the progression of the case.

These cases highlight a unique dynamic in child welfare teams as judges still have final say in case decisions. Judges can close cases against the wishes of team members or the entire team if they truly want to. Sometimes, team members use this reality to help them when they reach a standstill, essentially leaving the final decision to the judge. While other times the judge might just be present for the start of the conflict and come to a decision right then and there.

Participants on the losing end of a judge's decision also tended to accept those decisions better than those decisions that came from the team or FCM supervisors that went against their recommendations. This is because that judge has the final decision after hearing the home-based therapist's reasoning, there is really nowhere else to go from here beyond appeal to a higher court. When a team disagrees with the home-based therapist, they may get supervisors involved. When supervisors disagree with them, they can also present their case to the judge and see if they can get their recommendation accepted that way. But when the judge is the one not siding with the therapist, they have no other recourse unless aspects of the case become negative and there is new evidence to present in which case the judge can make them change their mind.

Outside factors. Finally, there are the occasional outside factors that will impact the result. Lily provided a good example of this as she described a conflict between herself and another therapist on the team. She was working with the

mother and the other therapist was working with the father. As they began couples counseling, it became clear that the father's therapist was not working well with the mother and was very combative toward her. Lily tried approaching him, but it did not impact his behavior and was really impacting her client so much so that they often had to spend most of their individual therapy time processing her frustration and anger towards this therapist and game planning for how to navigate other interactions with him. This conflict eventually resolved nicely for Lily and her client but was not through any actions they took. The father in this case eventually stopped engaging in services and could no longer be found after he had a warrant out for his arrest.

Self-Reflection and Learning from Past Conflicts

The last major theme that emerged from the data was the idea that participants engage in self-reflection as they navigate their conflicts. Participants talked about their reflection decisions they made and ways in which they expressed those decisions as well as how they responded to team members who disagreed with them. Lily talked about realizing that she was allowing another therapist's combative nature impact her handling of the case as she admitted to being in her "corner" a bit too much as well. Participants questioned themselves to ensure that they had done enough to prove their points, used the correct language and tone, and wondered if they needed to try different approaches when they failed. Tabitha recalled doing just that as she spoke about a difficult case she currently was working on stating,

> I have just been going through this in my head and such – just really…analyzing ok, what could I have done better, what can I do or what different approach can I take and stuff like that and I think a lot of what I do.

Participants also discussed how previous conflicts helped to shaped ways that they handle themselves now. Lily spoke about no longer "sweating the small stuff" as she did when she first started. She realized that she was too demanding of FCMs in the beginning and does not need them to be perfect to do her job well. She also realized that it is better sometimes to let more minor things slide so if you do need to address a larger conflict it is not one of many things you have an issue with.

Allison took a bad experience where she was talked down to and used it to help shape how she talks to both her clients and other professionals. She recalled how this negative experience stuck with her and stated that "if I'm gonna feel that crappy in a whole situation for months, I'm gonna take some things that's gonna stick with me and just take some stuff to stick with me when I work with clients and other professionals." What she hopes "sticks" with her is the importance of treating people with respect and listening to them with open minds.

Allison took that same experience and used it to shape her view of her work as a home-based therapist. She expressed how she did that by stating to herself,

> This is just the introduction to being a social worker and working with the system – sometimes people are gonna listen to you and sometimes they're not – all you can do is like, you know – what's your concerns? Document everything that you can and sometimes just hope for, you know, the best.

Expecting that not everyone on the team will agree with you or listen to you was a common occurrence with participants, who also adopted Allison's approach of making sure they expressed their concerns clearly and professionally and documented everything. In the end they also did what Allison stated, and hoped for the best.

A Proposed Model of Home-Based Therapists Experiencing and Resolving Conflict

The bulk of the findings presented have revolved around how the participants experienced conflict and how they went about resolving it. Through the coding process a model emerged (see Figure 2). This model represents how home-based therapists experience conflict from its emergence to the final team decision. It is important to note that due to demographics such as experience, age, and gender, as well as past experience with conflict and personality type, participants had a wide range of reactions and responded with a variety of approaches. It is also important to remember that, as was shown when describing the themes, some of the aspects of this model may be cyclical, such as when a team reaction causes a new conflict or forces a therapist to take a new approach to addressing the conflict.

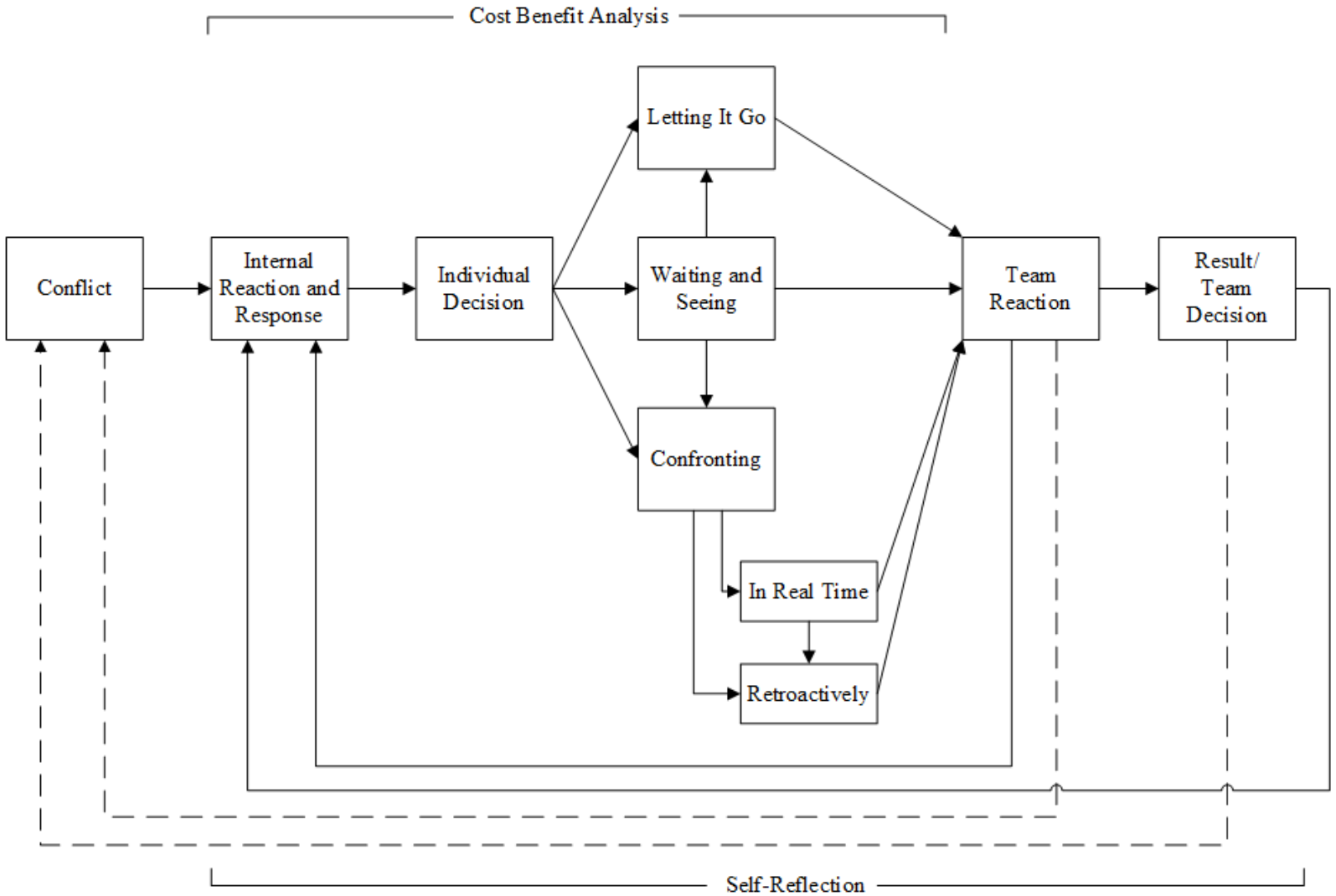

Figure 2: Model of Home-Based Therapists Experiencing and Resolving Conflict

The model starts with conflict, which can take various forms and present itself in various settings. Once the conflict emerges, the home-based therapist has an internal reaction which then leads them to make a decision on how to deal with the presenting conflict. Depending on the person and the situation, the decision may be to let the conflict go, wait and see if they will need to say something or confront it a later time, or they may confront the conflict in real time or retroactively. This decision process is primarily guided by a strategic cost-benefit analysis that is driven by what the home-based therapist thinks is best for their client, themselves, their agency or a combination. Once the home-based therapist acts on their decision about how to address conflict, the team will respond and react to the therapist's behavior. This reaction from team members may cause a new conflict if it is unprofessional, unethical, or otherwise problematic. This reaction will also cause another internal reaction for the therapist who will then have to decide if they need to address the team for their reaction or not. The team reaction leads to the team decision or result of the initial conflict. This too, could lead to an additional conflict and once again the therapist will need to decide if they need to act. They must also decide if they are satisfied with the end result or if they need to continue to challenge it and confront it, perhaps with a different approach. The entire process requires a level of self-reflection to ensure that the home-based therapist is acting professionally, ethically, and in the best interest of their client while still ensuring the safety of the children involved in the case.

It is important to note that this model can be cyclical and not all participants spoke about conflict that resolved itself nicely or satisfactory in their opinions with either the team agreeing with the participant's recommendation or the team coming up with a mutual agreed upon compromise or decision. It is also important to note that not all

participants traveled through this model in the same way or with the same level of confidence or support. Some participants were very supported by their agencies and team members while others were not. Additionally, some participants were able to make quick decisions regarding their actions within the presenting conflict while others needed more time to process information and gather their thoughts before deciding on a course of action.

The Impact of Collaboration

This study also focused on collaboration and its impact on MDTs and conflict. According to participants in this study, while conflict cannot be completely avoided, it can be easier to navigate when there is good collaboration. There were many themes that emerged describing what goes into good collaboration. Participants talked about needing to have members who are open to hearing what other team members have to say and recommend and are good communicators. Mutual respect and trust were also important factors and participants wanted to trust that each member would do their job and do it to the best of their ability without bias or a certain agenda. When this occurred, they would be more likely to be willing to hear a recommendation in opposition to their own and accept it if it was truly what was best for the child and family. This makes any potential disagreements less likely to become unprofessional. Participants were clear that they did not expect to have everyone agree with them all the time, but they also expected that disagreements would remain professional and not become personal or ego driven.

As participants discussed cases with good collaboration it was clear that they had many factors that made it easier for the team to navigate conflict. Julia talked about the

importance of everyone being open. When asked about how to make conflict easier to navigated she responded with,

> I guess just open-mindedness and receptiveness, which again, but that's also like a person to person thing, so it's hard to actually say what the guidelines should be, but in my head I'm just thinking more of the openness and the respect to come to each other to talk about it if it comes up because we're gonna disagree, it's gonna happen.

Again, the notion that conflict is unavoidable is present here, but she believes that there are ways, such as being open and receptive to others, that when present, can address it efficiently.

Participants discussed how they believe that good collaboration can make their work progress faster and be easier. There are multiple reasons for this such as not waiting long periods of time for responses from team members but Tabitha touched on another reason stating, "I think that also it just kind-of makes it easier for professionals stress-wise because it is very stressful to be on a team that's conflict-ridden." The work of child welfare professionals is already a stressful job, adding conflict just adds to that stress. However, when a team has strong collaboration. they can work through that conflict smoother which makes everyone's job easier and is better for the family.

The Model in Action

Now that I have examined and explained each step in the process that home-based therapists can experience within child welfare MDTs when conflict arises, I believe it is helpful to provide some examples of from start to finish to highlight how each step impacts the next one, as well as how past experiences can influence the initial reaction and decision of the home-based therapist.

Emily's example of being replaced by another therapist is an example that demonstrates many aspects of this model. Emily ultimately was removed from the case and replaced with another therapist from her agency. In this case Emily was working with the mother whose children were living with her sister as the aunt was providing kinship care for the children. According to Emily, the aunt made false statements about Emily's work with her client to the FCM because she wanted to adopt the children and felt like the Emily was a threat to that as she was helping the mother address her issues.

When the FCM first brought this to Emily, she did not ask her about it but instead told her the aunt wanted her off the case and so they were preparing to remove her. Emily felt frustrated because she believed she was doing good work with this client and could point to achievements like getting the client off the streets as signs of improvements. She decided that she would challenge this decision because she felt like it was in the best interest of the client to continue the work they had done together and not have to start off with a new therapist. Emily first emailed the FCM to defend herself and highlight the progress the client had made working with her. This is the confronting in real time approach because the FCM has communicated with her via email originally. When she did not get a response (no response is also considered a team reaction) she was again frustrated and decided to bring in her supervisor. This demonstrates how the team reaction can lead to another internal reaction for the therapist and another decision point. Emily again opted to confront the conflict but this time using her supervisor.

Unfortunately for Emily the supervisor did not want to confront the conflict and opted to use the letting it go approach which then forced Emily to use it as well. The supervisor could have been thinking about the relationship with this FCM and the entire

DCS office as the agency was not going to be losing the referral, they just needed to switch therapists. With this supervisor being new as well, she may not have had enough goodwill or social capital built up to confront this conflict.

In this example, there was conflict over whether Emily should remain the client's therapist or if the team should listen to the request of the kinship caregiver and remove her. Emily had an internal reaction to that (frustration) and decided to confront it through the same forum the conflict started, email. There was no response which lead to more frustration and choosing to bring in her supervisor. The supervisor opted to utilize the letting it go approach. As a result, the team got their desired outcome against the home-based therapist's recommendations.

Adam's case where he wanted to terminate his therapy with his client (the child) is another good example of how this model can be cyclical with team reactions leading to potentially new responses to the initial conflict from the home-based therapist. Here the conflict resulted from Adam who wanted to terminate his services because he felt the client no longer needed therapy. The GAL and FCM however made it clear that they wanted him to stay and Adam even stated it was more of a demand than a request. That then caused him some confusion and frustration because he felt like he had the right and the expertise to make that clinical judgments. There was also some annoyance as he felt the GAL in particular did not understand his role and was trying to dictate the therapy and therapeutic decisions for this case.

As Adam entered his decision-making process, he decided it was unethical and a misuse of resource to continue working on this case. Based on this evaluation and the way the GAL and FCM presented their desire for him to remain on the case Adam

decided to confront this conflict directly. In his first attempt Adam tried to educate the GAL on his role as the home-based therapist and how he should be used because he felt like the GAL only wanted him around in case something bad happened and to be more of a "babysitter" in Adam's words than a therapist. He then made the clinical argument of not wanting this child to resent him and therapy because he was forced to spend time with Adam when they really didn't have anything to address. He also made the ethical argument about ending services. None of these approaches convinced the GAL to change his mind. The GAL's reaction to Adam's confronting the conflict was still professional but ultimately, he was not swayed, and his recommendation did not change so the team's decision at that point was to continue to have Adam provide therapy.

At this point, Adam needed to decide what he was going to do with this team decision. He did not want to let it go and he felt like waiting and seeing what might happen next was exactly what they wanted him to do and exactly what he was arguing against. This left him one option, confronting it again. However, this time he used a new approach. Keeping in mind the importance of the working relationship with DCS both for himself and for his agency, Adam opted to bring in his supervisor for her opinion. He told her everything and knew that she should agree with him, so this was more for the team than for him. He did not feel like he needed reassurance that he was doing the right thing but perhaps his team did. This showed the team that he had really thought about this decision, which he did, and it was ethically and clinically the right choice. He stated once he told everyone that his supervisor supported his decision, the GAL and FCM changed their tones from demanding that he stay to hoping that he would. With that, he was free to close out services without major objections. Even in closing out services though, he still

made sure to tell the team that he would take the case back on if therapy for the child every became necessary again. This conflict took two cycles using the confronting approach but ultimately was resolved to the therapist's liking.

There was the original conflict (Adam wanted to close services, the GAL and FCM did not) which caused Adam's internal reaction (frustration, confusion, annoyance). He went through his decision-making process and opted to confront it in real time using education and ethics. The team responded professionally but did not change their mind so the team decision at that point was for Adam to stay (going against the home-based therapist). This caused another internal reaction (more frustration) and another decision point. Adam again chose to confront it, but this timed went to a higher up, his supervisor. The team again responded professionally, listening to him and ultimately changed the team decision to grant Adam's recommendation. With that, the conflict was resolved.

Chapter V: Discussion

This qualitative study focused on child welfare MDTs and how one member, the home-based therapist, experiences and navigates conflict when it inevitably emerges. Many of the concepts reported on in this study have previously been studied in multiple fields and settings but certain concepts and how they relate to each other have yet to eb addressed in the literature thus far. In this chapter, I further explore the findings of this study and how they relate to the current literature. Additionally, I will point out where they can be used to enhance our understanding of conflict and collaboration within child welfare MDTs.

Examining the Findings

While the proposal model presented in this study is a new addition to the literature there are several themes that emerged that are also found in the literature when it comes to MDTs. However, this study takes a more focus approach, looking specifically at home-based therapists which allows the researcher to compare experiences of home-based therapists to that of other team members that have been studied in the literature. While participants shared many factors with previously discussed findings and theories, there are multiple areas where this study adds new levels of understanding or different perspectives.

Conflicts Emerging in MDTs

Types of conflict. Jehn (1995) presented two types of conflict: task conflict and relationship conflict. This study also presents two types which closely resemble those that Jehn (1995) found. Elements of conflict based on system issues relates to task conflict because it is conflict that results from the dynamic and organization of the child welfare

system. Jehn's (1995) task conflict occurs when team members have opposing viewpoints, ideas, and thoughts related to the task. This also occurred in the conflicts that participants described as related to system issues. What is more, because of the nature of the child welfare system, participants expected this type of conflict because they knew that for certain cases their role would put them at odds with other members. With different team members being assigned to different clients there is a greater chance they will have different information and perspectives resulting in different recommendations which is the cause of task conflict. This set up is also why participants expected this type of conflict.

Conflict due to system issues does differ from task conflict in some ways, however. Just because team members have different roles and clients, does not mean that they have to disagree. It is not a guarantee, but many participants point to it as a root cause in many of their conflicts, as Julia did when she highlighted the differences between her role as a therapist for a parent and the CASA's role advocating for the children. Conflict due to system issues also extends beyond task conflict as participants expressed some conflicts related to the bureaucratic nature of the child welfare system. This takes task conflict to a more macro level as there are higher level elements that may cause opposing recommendations. This particular aspect of conflict due to system issues more closely resembles the additional conflict type to Jehn's (1995) original work, process conflict, presented by de Wit et al. (2012). With DCS policies and procedures often being the source of this type of conflict due to system issues, there is are elements of process conflict found in conflicts due to system issues as well.

The second type of conflict, relationship conflict (Jehn, 1995) is very closely related to this study's second type of conflict, conflict due to team members. Both of these conflicts emerge due to personal issues between members. Participants spoke about conflicts that either emerged or escalated due to a member's combative tone or bias behavior towards their client or themselves. The notion that task conflict can lead into relationship conflict is also evident in this study. Tabitha discussed how she disagreed with the team on a service referral they wanted to make for her client (task conflict) but due to the confrontational and demeaning nature of how they talked to her about their disagreement with her, it quickly turned personal (relationship conflict) and impacted their working relationship.

In addition to task and relationships conflict, process conflict is also a possibility (de Wit et al., 2012) but was not mentioned as frequently during the interview process as task or relationship conflict. However, Diana did have a conflict that was in part a process conflict as she ended up doing what she felt was the FCM's job of researching available services providers for her client. This part of the conflict revolved around delegating responsibility and highlights one of the causes of conflict mentioned in this study of members not being accountable or not doing their job. Here the conflict was not over whether therapeutic visits should occur, the team all agreed they should, the conflict arouse because the FCM was not making the referral fast enough for Diana making it a process conflict.

Edmund's (2010) three levels of conflict did not seem as applicable to the findings of this study but there are some similarities. The first level of event-based conflict is very similar to Jehn's (1995) task conflict and thus conflict due to system

issues in this study. All three result from members having different opinions, information, or interpretations of events. For the participants in this study, these differences resulted in opposing recommendations.

Communicative-affect conflict is Edmund's (2010) second type of conflict and results from issues that are meaningful enough that they have a significant impact on the persons involved or the whole group but miscommunication and/or a contemptible affect has developed during the conflict period. Parts of this can be seen in this study as the issues that child welfare MDT team members discuss are very important and the participants in this study took their role of advocate for their client very seriously. So, while they may not have a personal stake in the conflict, they do have a strong professional stake. According to Edmund (2010), "dirty fighting" can occur at this level with members bringing up past disputes and engaging in power struggles. This is not something that participants shared during interviews. Despite their frustrations and annoyance with other team members, participants never mentioned any dirty tactics they used as they engaged in conflicts, nor did they suspect others of "fighting dirty." Some participants singled out times when members were more combative in nature than they deemed appropriate, but it did not reach the level of what Edmund (2010) describes.

Edmund's (2010) final degree of conflict, identity-based conflict also did not appear in the data of this study. Perhaps it is due to the nature of child welfare MDTs that their identity was never threatened, even as they experience conflict. Child welfare MDTs are well defined groups with an aim to provide children with a safe, stable, and permanent family whether through reunification, adoption, or guardianship. Even when members disagree, they know that they are still part of this team with this goal. Perhaps

there may be elements of identity-based when the permanency plan switches to adoption from reunification but there were no instances when a participant talked about this as they retold their experiences with conflict.

The complicated relationship that home-based therapists and their agencies can have with DCS as both the referral and funding source cannot be ignored when examining types of conflict and how they manifest in child welfare MDTs. As was indicated in the data, many participants spoke about not wanting to upset FCMs or DCS as a whole for fear of retribution against them, their client, or their agency. This dynamic can color all types of conflict as there is a clear power differential.

Causes of conflict. There were many reasons behind the conflict that participants described that have been cited in the literature as potential causes of conflicts when working in groups. Some causes mentioned in the literature such as scheduling issues (Kim et al., 2016) and lack of accountability (Brown et al., 2011) and were also mentioned by participants but not as the sole cause of the conflict. Issues related to lack of communication or a team member being unreliable were usually mention as a fact that made resolving the conflict more challenging but not as the sole reason for the conflicts that were shared by participants.

Participants spoke about conflicts due to different core values of team members based on their position as highlighted by Frost et al.'s (2005) work. It is not surprising that conflict can occur within groups when members have different socializations and potentially contradictory roles (Robbins et al., 2011). The most common core value difference in this study appeared to revolve around advocacy. There were many participants who spoke of conflicts that emerged because they valued their role of

advocate for their client, while other members were more concerned with other family members. Socialization also played a role in some of the conflicts described with some members questioning how other team members were trained because their views differed so greatly compared to their own. Trainings that FCM, GALs, or CASAs go through before entering the field would be an example of a professional socialization, but personal socializations can also be a route in conflict. Elizabeth questioned if she experienced this with a GAL from a wealthy suburb who was not supportive of the family's housing in a poor inner city neighborhood as Elizabeth believed this person did not know what it was like to live paycheck to paycheck, or in the case of this family have to work really hard to even live paycheck to paycheck. The GAL, who was new, had not been exposed to families in this socioeconomic status to the extent that Elizabeth and the rest of the team had, which ultimately led to her consenting opinion about the housing and the conflict that so frustrated Elizabeth.

Other common causes of conflict in MDTs reported in the literature include team members having different information about the case, different objectives (Frost & Robinson, 2007; Frost et al., 2005), or different opinions when it comes to creating goals and referring services (Kim et al., 2016). All of these are present in the cases that participants described in their interviews. Lily recalled a conflict where she had a very different opinion than the rest of the team and made it known only to be provided with additional information the next week that made her see why the team all opposed her recommendations. She immediately changed her recommendation and wish she had been operating with the same information as everyone else.

Power and status differences are common causes of conflict found in the literature Frost et al., 2005; Kim et al., 2016; Magnuson, Patten, & Looysen, 2012) and can also be seen in some of the conflicts described in this study. Allison spoke of multiple conflicts she had with teams that included psychiatrists because she felt like they looked down on her as a social worker. There were also conflicts regarding terminating the home-based therapist's involvement in cases that have traces of power struggles at their core. In Adam's case, he wanted to end his services but got pushback from the GAL and the FCM. The GAL as a court appointed advocate for the child has a certain level of authority to their position, as does the FCM who represents the state. It was not until Adam brought his supervisor in that he was listened to. Perhaps it was his supervisor's authority that helped to tip to scales of power in his favor. Adam's case also highlights another cause of conflict reported by Frost and Robinson (2007), role confusion. He believed that the GAL did not fully understand his role as therapist for the child which led in part to his initial objection to Adam terminating services. These power struggles can occur within the same agency with supervisor and employee. This is what happened to Emily when was removed from her case against her will by the FCM. Without the support of her supervisor, she had to reluctantly accept her removal despite her pleas to her supervisor to fight it. She did not have as much as power as the FCM and could not go over her supervisor.

Finally, conflict can also arise when team members have different views of the client (Frost et al., 2005). This was also seen in this study as participants point to bias against their client as a contributing factor to conflict. As Tabitha discussed a conflict between herself and the rest of the team regarding what to do with her client's failed drug

screens, she was able to pinpoint the root cause to how she viewed her client versus how others did. Despite failing her drug screens for methamphetamine, Tabitha believed her client when she stated she was not using drugs and there must be some issue with the test. However, the other members of the team thought she was lying and was trying to manipulate Tabitha who was newer to the profession. With the two sides coming to the table with such vastly different viewpoints, it was no wonder that they did not agree on the next course of action to take as the team sought to provide consequences for the client's relapse and Tabitha sought to seek clarification on the accuracy of the drug screens.

Role of conflict. Participants also established that conflict could serve a functional purpose, echoing the work of Coser (1956), specifically that conflict can bring a group together and re-establish unity. What is interesting about these findings though is that unity did not always apply to the whole group. Some participants discussed how certain conflicts aided in the team forming multiple alliance as Lily found with team members as they bonded and then teamed up and began to collaborate over their mutual shock from the initial conflict. Other participants spoke about conflicts a means to bring focus back to the team's main tasks. This only occurred if the team was able to address the conflict though as the conflict also had the potential to spiral out and lead to a divided, combative team. Other participants shared experiences where a conflict allowed everyone to hear each other side which is the first step of trying to become a unified team.

Internal Reactions and Responses

The idea of examining how home-based therapists respond internally to conflict has not yet been explored in the literature. How team members react to conflict in general is under-studied as a topic. Jehn (1995) states that conflict can result in annoyance, tension, and hostility. Annoyance was a common feeling expressed by participants as they discussed their conflicts. They also expressed different levels of tension as some even dreaded going to certain team meetings and spoke about being able to feel the tension in the room. Hostility did not come up, though perhaps more mild forms of it were present, especially when participants' therapeutic knowledge or practices were questioned. Adam had a thought of "how dare she" when he was questioned by a team member if he was doing enough for his client which may have been the closest reaction to hostility shared in this study.

By far the most common feeling was frustration which does appear in more recent literature as a common reaction to conflict (Weingart, Behfar, Bendersky, Todorova, & Jehn, 2015). Frustrations stemmed from conflicts related to the system issues and team member issues. Participants expressed frustration over other team members being biased towards their client, not be open-minded to their recommendations, being unreasonable in their eyes, and having problematic communication. This feeling was also present when team members talked about collaboration as Drabble (2007) found that people complained that interprofessional collaboration could be burdensome.

Feelings of anger were also common and to be expected when participants found themselves in conflict with another team member (Drabble, 2007; Weingart et al., 2015). Weingart et al. (2015) states that these feeling are more frequently experienced together

when the members are more entrenched in their positions and clear about their desires. The data in this study also show this as well, as those participants that described their anger did so mostly when describing cases that they had been working on for long periods of time and/or felt a strong connection to the client and the outcome of the case.

An interesting aspect from the data regarding these initial internal reactions is the conscious efforts the made of the internal responses to the reactions of the home-based therapists not to let their negative feelings impact their decision-making or response. Many talked about the efforts they took not to let their personal feelings impact how they respond because they wanted the other members to be able to hear what they had to say and not feel attacked or get defensive. This speaks to the types of conflict, particular event-based conflict and communicative-affect conflict (Edmund, 2010). As was previous discussed, event-based conflict is easier to address than communicative-affect conflict which often employs "dirty fighting." Participants understood this, either inherently or through experience, and made great efforts not to engage in the type of in-fighting that could derail a case's progression. They wanted to keep the conflict professional and based on the facts and the task at hand. Because of this they made sure to keep their emotions, whatever they were, in check before responding to the conflict.

This effort to avoid the more negative sides of conflict expression helps to avoid what is known as a conflict spiral (Weingart et al., 2015). This can occur when one team member expressed the conflict in an inappropriate or unprofessional way. The other team member as the receiver of those statements perceived what was said and the tone and has a negative emotional reaction it. They then express themselves in response in a negative and unprofessional way, perhaps mirroring the first team member. This team member

now perceives the message, has an emotional reaction, and the cycle continues. By the home-based therapists cutting off the cycle on their end by not letting the negative emotions seep through their expression, they ensure that the conflict will not spiral out of control and has a better chance of getting resolved. Though no one mentioned a potential conflict spiral scenario, participants did talk about the importance of perception and the role that their unchecked emotions could play in a possible negative perception from another team member.

Decision-Making Process

When it comes to examining the decision-making process of child welfare professionals, the focus in the literature has centered around how they make case decisions. This is important but not the aim of this study which seeks to take a more focused look at when and how they decide to express those decisions and recommendations when they differ from others on the team. In this study, it is not important that the home-based therapist decided that they were going to recommend therapeutic visits, couples counseling, suspend visitations, or even how they got those decisions. For this study, what is important is when and how the therapist recognizes conflict and what process they engaged in to decide what action to take and how they were going to do that action.

Despite this distinction between what has been studied and presented in the literature and what was studied and presented for this study, there are important similarities to point out. One similarity is the idea of avoiding risk or harm. When decided, case decisions such as placement decisions of children, child welfare professionals consider any safety concerns and use the risk of harm to the child as a key

guiding factor (Kettle, 2015; Nyathi, 2018). This idea also played a contributing factor for participants in this study as they decided whether to confront conflict, wait and see how it progresses, or let it go entirely. Though assessing the risk of harm to the client or to the children in the case contributed to their decision, as it helped to determine the significance and immediacy of their response, it was not the only factor. Participants in this study took that same concept of assessing the risk and significance of harm and brought it to the team. When coming to a decision using the risk of harm as a guiding factor, the therapist would question themselves about what will happen to the client or to the children if the recommendation was accepted or rejected. Participants in this study likely used that reasoning to help confirm their decision but they also asked themselves questions about harm to the client regarding even making the recommendation as Dave did before he brought up recommendations. Also, like Dave and many others, when deciding how to respond to conflict, home-based therapists must consider how their response will be taken by the team and if it could have any negative impact on their client, themselves, or their agency.

With this decision-making process, home-based therapists are acknowledging that their fellow child welfare professionals are human and may get upset, hold grudges, take conflicts personal, and, more importantly and alarming, may have those feelings impact their interaction and decisions regarding the therapists' client. This fear was expressed by several participants and is not unfounded either as case workers admitted to negative feelings towards parents on their caseloads and even admitted to using case plans overloaded with too many services as a form of punishment (Smith (2008). Participants in this current study viewed themselves as advocates for their clients and did not want to

cause any harm to come to their clients. This perspective made them carefully consider when and how to confront certain team members that had the power to negatively impact their clients.

Making decisions in child welfare cases also has an element of intuition and professional judgement (Nyathi, 2018; Whittaker, 2018). Child welfare professionals rely on many factors when making decisions such as assessments, family history, interactions with the family and available resources but their own personal experience is the one that also comes into to play when they decide how best to address conflict (Nyathi, 2018; Whittaker, 2018). Whittaker (2018) states that this intuition and professional experience, not surprisingly, hones and develops over time as the professional gains more experience and comfort in their role. This appears to be true in this study as well. Melissa who only had 3 months of experience at the time of her interview described feeling vulnerable during conflicts which made her question her decisions. Dave, who had been practicing for 6 months, described how he often used the retroactive approach to confronting conflict because the speed of the decisions that were made in team meetings were still too fast for him. On the other spectrum, Adam who had been practicing for three years, talked about how quickly he could judge a fellow team member's style of communication and adjusts his approach to match when confronting a conflict with them.

The idea that past conflicts and experience help to shape participants' current decision-making process also relates to the decision-making literature in child welfare (Nyathi, 2018; Whittaker, 2018). Lily provided an example of how intuition and experience grow over time as she described how she has changed her approach to conflict from earlier in her career. Many participants described how they learned from previous

conflicts and how that have shaped their current practice and approach to conflict within MDTs. Even those with less experience like Dave, Lauren, and Edward discussed how they are learning from their current conflicts.

Response Options

There is a variety of literature regarding the topic of conflict resolution within groups or teams spanning many different disciplines. A popular way to look at conflict resolution is through the Managerial Grid (Blake & Mouton, 1964) as it has been reimagined multiple times since it's conception. Rahim and Bonoma (1979) provide their own assessment of the five options. In this study, this researcher presents a model with three response options that participants employed when faced with their conflicts, but they share many characteristics of what has already been presented in the literature. One distinction that needs to be made though is that Rahim and Bonoma (1979) categorized their different options based on a continuum of choices individuals made based on their own self-interest versus the interest of others. When dealing with home-based therapists in a child welfare setting, the idea of self-interest sounds unethical. Instead it is more about what they think is right for their client and the case versus the concerns for the other professionals on the team and what they think, though they still want to be respected and believe their recommendations should be followed. With this understanding, the similarities between what Rahim and Bonoma (1979) presented and what emerged from the data in this study start to become evident, though there are key differences that will be pointed out.

The first option presented in the model is letting it go. Here the home-based therapists decide to let the conflict go despite their objections to what this means. This is

similar in ways to two styles presented by Rahim and Bonoma (1979): obliging and avoiding. In obliging the person has a low concern for themselves and a high concern for others and will often give in to the other side rather than try to engage them in seeking alternatives. Avoiding (low concerns for self and others) involves the person ignoring the conflict or changing the conversation so they do not have to address it.

At first glance it may appear that letting it go fits nicely into both of these styles of conflict resolution. The therapist is giving into other team members' recommendations but the data in this study suggest that it does not come from a passive or submissive stance like the corresponding styles of Rahim and Bonoma (1979) suggest. This is where the notion of concern for self does not carry over to this study as participants regularly stated they attempted to take their own emotions and egos out of the conflicts they experienced. Many spoke about advocating for the clients and having an ethical obligation to what is best for them. This obligation to the client and the ability to think both in the short term and long term led many participants to let certain minor conflicts go. There is an element of concern for others, which in this case would be the other team members as Rahim and Bonoma (1979) suggest but this concern with appeasing them still serves their clients. Participants who used this approached justified it by saying they were concerned there might be retaliation against their client or there might be resistant that would build up if they became the team member who constantly fought with others to get their way. This could eventually backfire on them if there were more significant conflicts as the case progressed and now other professionals are less likely to be listen to them with open minds because they were too confrontational earlier in the case. Thus,

letting it go still comes from a place where the person is operating from a place of high concern for their position but can also see the benefit of being seen as a team player.

Complicating matters slightly is also the fact that the therapist also has an obligation to keep the children of the case safe as well. This means if a therapist is working with the mother who desperately wants her children back but cannot provide a safe and healthy environment for them and refuses to address the issues that caused removal in the first place, they will not be able to advocate for her as she hopes. In this case, if the therapist opts for letting the conflict go in favor of what the other members recommend they are actually coming from a stance of being more concerned with others than their client but now the "others" are the children which they have an ethical obligation to protect. This points to the fact that ethical obligation of social workers or specifically home-based therapists working in child welfare may be different than those for which the Managerial Grid was originally intended.

Despite the argument that letting it go is more of a strategic, conscious, and active choice than Rahim and Bonoma's (1979) obliging and avoiding styles there may be times when therapists do simply oblige or avoid conflict because they are uncomfortable, which would more accurately align with how Rahim and Bonoma (1979) conceptualize these options. Ben mentioned perhaps the closest occurrence to this when discussing how team members were "bashing" his client who was not present at the meeting. He did not engage in putting the client down like the rest of his team but did not confront them or get them to stop either, which she stated he probably should have but was just "too passive." However, this is just one small example, and, in fact, there were more participants, like

Dave, who talked about confronting conflict despite it being uncomfortable because it is viewed as part of the job.

The second option of the model found in this study, waiting and seeing, also has elements of obliging to it as participants agree to the counter recommendation over their own. What makes this option different though is the fact that it is not the final option or end result of the conflict. As the name implies, the home-based therapist is not convinced of the recommendation but is willing to see if it will work. This is a temporary fix, similar to the compromising style of Rahim and Bonoma (1979) which works on trade-offs and maximizing wins and minimizes loses for as many people as possible. Even if it is not stated, the home-based therapist has made a trade-off of sorts. They are willing to accept another team member's recommendation, providing that the circumstances improve or, depending on the situation, remain the same. If there is deterioration or the needed improvement is not achieved, then the waiting and seeing turns to the third response option of confronting. The therapist can then come to the team with some more power as they have allowed the team to try it their way and now there is evidence that it did not work. If it did work, then all should be happy because the case is progressing as it should, and the therapist can now let that conflict go.

Confronting the conflict is the third option in this model and is similar to two styles Rahim and Bonoma (1979) present: integrating and compromising. Integrating consists of cooperative behaviors aimed at obtaining mutually favored solutions. People using this approach will focus on shared goals and use creativity, flexibility and open communication and information sharing to convince others to agree with them. Participants shared many strategies they use when confronting conflict. One such strategy

was to be factual when presenting their side. This information sharing is found in integrating as well. Participants also talked frequently about refocusing the teams in times of conflict, with the hope that reminding everyone of their purpose and goal as a child welfare team will aid in resolving the conflict. This is a call to their shared goal of providing a safe and permanent place for the children involved to live and thrive. Participants also would bring in ethics, both their own professional ethics but also the more global ethics of all those working in the child welfare system. This was often used as an appeal to fairness, such as when Melissa used this technique when her team was prematurely giving up on the possible of reunification.

What is interesting in comparing the response options presented in this study compared to the five styles Rahim and Bonoma (1979) presented in their work is that one style, dominance, does not seem to be used by home-based therapist at all. However, through their retelling of conflicts, it appears the participants believed that others used this style from time to time. Those who use dominance want the other side to concede and will attempt to do this by using a more confrontational approach where they are very direct with their communication, continuing argue their side, and attempt to control the conversation (Rahim & Bonoma,1979). These tactics appear to be counterintuitive to the therapeutic approach participants were trained in and apply to their interactions with clients and other professional team members as well. Thus, dominance does not appear to be a preferred method of home-based therapists when resolving conflict. Another reason for this could be a result of the important relationship participants need to maintain with the state child welfare system. Many participants discussed the need to have a good working relationship with DCS for themselves as therapists for reasons relating to them

personally and to their clients. Others also spoke about how this relationship can impact their agency who rely on DCS for referrals. With all these factors coming into play, dominance seems to be a style that is too overpowering and ignores the importance of maintaining a positive working relationship with key team members like the FCM, GAL, or CASA rendering it ineffective and ignored by home-based therapists.

Team Reactions

How the team reacts to the home-based therapist's response to the conflict is important. Like in the conflict spiral (Weingart et al., 2015) the manner to which they respond will influence how the therapist perceives their response and thus their next course of action. As was shown in the data and the model, this reaction will lead to a team decision or a result for the conflict but it will also lead to another internal response from the therapist and possibly even a new conflict if the team's response is overly negative and deemed unprofessional by the therapist. Here is where the model can become cyclical like the conflict spiral (Weingart et al., 2015). However, since the participants all discussed trying to avoid overly biased, aggressive, and personal language and tone when confronting conflict, they, by doing so, have invited the other team members to do the same, though this is not always the case. When this occurred and a team member responding aggressively, a new conflict, now categorized as relationship conflict, could emerge.

Another team reaction that became problematic for the participants is when they were ignored. This is where the conflict may turn from task conflict to relationship and process conflict. This is what happened with Diana's case when the FCM was not timely in making the referral to an agency that could do therapeutic visits. The team had worked

through the task conflict but with the FCM's lack of follow through, both in the referral and communicating with Diana, a new conflict emerged. Initially, Diana gave the FCM the benefit of the doubt, utilizing the wait and see approach before the confronting response after the FCM still did not make the necessary progress. Now the conflict was no longer about what was needed (therapeutic services) but when it should be implemented making the conflict transition from task to process. Additionally, Diana became upset with the FCM and frustrated that she ended up doing part of her responsibility so there were also some aspects of relationship conflict that entered into the relationship. With these new conflicts emerging, Diana went backwards in the model as she now had to decide how to address the new conflicts that emerged when the FCM did not make the referral in a timely manner or respond to Diana's requests and suggestions.

Examples such as that of Diana show how complicated navigating conflict can be in child welfare MDTs. Sometimes there is more to do than simply address a conflict as that conflict can produce new conflicts that also have to be addressed. There were several simple examples though of participants confronting a conflict and team members hearing them out appropriately. When this occurs, the conflict transitions smoothly to the potential last step of the team decision or end result.

Team Decisions/Results

How individual child welfare professionals and child welfare teams come to decisions regarding their cases was not the focus of this study. Whittaker (2018) points out that this has been well studied in the literature both from a sociological perspective and more recently with psychological modules. The decision-making process that was the focal point of this study centered around how participants made decision about what

approach to use to best address the conflict they experienced, not how they came to initial recommendations. With the focus on conflict, the importance of the team decision here is whether it is in support of the participants' stance or if it goes against their recommendations.

When the team agrees with the home-based therapist the conflict has reached its conclusion and the model will not loop back. There are no more decisions to make or work to do for the home-based therapist with this particular conflict. However, when the team does not agree with them, the home-based therapist must reenter the decision-making phase and decide how best to proceed. This is where power differential can come into play, particularly if it is the FCM or the GAL who is the one disagreeing with the therapist. This was seen in Adam's case where he felt it was appropriate to end his therapy with the child involved in the case. One would think that a service provider who worked regularly with the client would be able to tell the team when services were no longer needed or appropriate. That did not happen here, at least not initially, as Adam was told he would remain on the case because that is what the FCM and GAL wanted. It took his supervisor supporting his decision for the team to finally relent. The reason Adam needed to get his supervisor involved is because the FCM has great decision-making power on the team and the GAL is court appointed to advocate for the child and thus is very influential, especially with matters related to the children. In this particular case, the FCM believed that the GAL's opinion trumped Adam's, even as the child's therapist making a recommendation about therapy. Perhaps it was also that Adam wanted to end services and the GAL wanted to keep them which is safer by nature and less likely to backfire in the eyes of DCS.

Regardless of their reasoning, this example shows how the home-based therapist has a decision to make when the team decision is not in their favor. In Adam's case he had confronted the team only to be overruled. He then decided to confront the conflict again but this time with his supervisor. The team reacted with some reluctance but ultimately allowed him to terminate services.

This study also showed that there is a third options teams can utilize in addition to agreeing or disagreeing with a specific team member. They give their deciding power to a third party that has more authority than any of them have. Going to a higher authority like the judge or the FCM's supervisor is an easy out for a team that cannot agree on a decision and does not want to pick sides themselves. While some participants wanted to avoid this tactic, others welcomed it, especially if it was going to judge. Some participants even discussed this option as a fallback with the knowledge that they could always suggest seeing what the judge decides when a team decision looked unlikely or things were going to get too intense.

Collaboration

Participants shared many factors that contributed to strong collaboration which are also found in the literature. Many of the factors to strong collaboration can also help address conflicts. Strong communication was often cited as a key factor to good collaboration and is common in the literature (Horwath & Morrison, 2007; Korazim-Korosy et al., 2007; Spath et al., 2008). This communication took the form of open, respectful, and clear dialogs while in team meetings as well informative email chains. Participants also discussed the importance of leadership, another factor in the literature (Spath et al., 2008). Participants differed in this study as to where this leadership should

come from as some stated it was the FCM that set the tone for the team, while others stated it could come from any team member. Horwath and Morrison (2007) discuss that being able to trust others on the team was also a factor in how well the team collaborated and this emerged in this study as well. Participants stated they had to trust that each member would do their job to the best of their ability and use the information the therapist provides them appropriately.

As participants discussed examples of strong collaboration and those teams that were lacking collaboration, an interesting observation began to emerge. Participants had examples of strong and poor collaboration in both small and larger teams. It might be thought that collaboration is easier with fewer people as there are fewer barriers such as scheduling difficulties (Easen et al., 2000; Kim et al., 2016; Lalayants, 2013) that could come into play. Larger teams also have more potential for more members with different philosophies, practices, and goals of team members which can act as barriers to collaboration (Lalayants, 2013). However, some participants stated that larger teams force them to collaborate more than smaller teams do because of how complicated they can be. Those who spoke of this also stated that smaller teams can "get by" with poor communication, though it is still not ideal. This seems to reinforce key factors of collaboration including strong communication, strong leadership, and successful teaming that Spath et al. (2008) identified. The size of the team may not be important if it is filled with professionals who have these skills, a willingness to work together, and interpersonal skills like communication skills and conflict management which Korazim-Korosy et al. (2007) found to be vital for good collaboration. Participants in this study seem to agree based on their experiences.

Another element of collaboration that appeared in the data of this study and also in the model was the idea of self-reflection. Both Gitlin et al. (1994) and Bronstein (2003) use it in their models of collaboration, though slightly differently. Gitlin et al.'s (1994) model is influenced by social exchange theory so members reflect on how much effort they need to put forth and what they will get in return. This is not how participants in this study referred to their self-flection. Participants talked about a continual processing where they reflect on their decisions to ensure they are engaging in ethical and professional behavior that benefits their client and is not "ego-driven" as Dave put it.

Participants also used their fellow team members' reactions as catalysts to reflect in order to ensure they not only had an appropriate recommendation but delivered it in a fair, fact-based manner that demonstrated their expertise without coming across as belittling to their fellow team members. These notions relate to reflection in Bronstein's (2003) model which involves members reflecting on how they work with the team and using feedback loops to help improve their working relationships with team members and the overall effectiveness of the team. These are seen is the way participants like Dave engaged in self-reflection after confronting conflict, questioning everything from his tone, voice level, and speed in which he delivered his message. Julia provided an example of reflecting on her approach with an FCM as she felt that she engaged with her using multiple therapeutic skills only to have that frustrate the FCM who felt like she was demeaning her. As a final example, Tabitha stated she questions both her actions and approach after she addresses conflict. All of these examples, as well as others not mentioned but found in this study, all appear to fall in line with Bronstein's (2003) view of how reflection occurs in collaboration.

Finally, participants were also able to state how collaboration impacted their work and the case. All participants stated that they felt good collaboration improved the outcome of the cases and sometimes even the speed to which they close. For those who stated it can take longer, the consensus was that in the end it was good thing because issues came to light that needed to be addressed to better set the family up for success after closure. Perhaps what is more interesting and unique to this study is what the home-based therapists said collaboration did for their work as therapists. According to the participants, strong collaboration makes their work easier as a therapist because they are getting more information and getting it in a timely manner. They can then use this information in their therapy to give it a better sense of direction and address client issues that they might otherwise be unaware of such as issues that a visitation supervisor witnessed and shared. Without the benefits of strong collaboration, therapy runs the risk of not fully addressing the needs of the client or preparing them for what lies ahead in their case. The therapist is then left to "take a shot in the dark" like Julia stated or "just creating things out of thin air based on observations" like Diana. This is not ideal, and everyone knew it, which speaks to the importance of good collaboration in child welfare MDTs.

Implications

This study has implications for the child welfare field, both in terms of training and educational opportunities. This study offers new insight into the minds of home-based therapists as they experience conflict. From analyzing the data, it appears that better understanding of collaboration and conflict will improve the effectiveness of child welfare MDTs and better serve the families involved in the child welfare system. This

may be especially true for incoming therapists who more often admitted to feelings of being overwhelmed or unprepared to address conflict in the moment than their counterparts with more experience. Experiencing conflict among other professionals on the team may be considered part of professional socialization for home-based therapists. Participants admitted that they were bound to experience some form of conflict through their work with MDTs and some described it as part of the job, but it is still not something regularly discussed in their graduate courses. This might partly explain why newer therapist might be more likely to struggle with it, though not all did. Using this knowledge can help better train incoming therapists to know what to expect when working with the multiple service providers and professionals that may make up their treatment team. It can also encourage them to share this information with others on the team as well as how they would like to see collaboration and conflict resolution occur within the team. It will not substitute the knowledge they will obtain from being on the job and experiencing conflict firsthand, but it might provide them a better start point they currently have now.

In this study, many of the newer therapists tended to speak about how they were at times unprepared for the emergence of conflict and how this impacted their response to it. Dave spoke about his reliance on addressing conflict retroactively due to being unprepared or too shocked to address it in real time when it emerged in team meetings. Perhaps if he had more training or education about the conflict he will likely face as a home-based therapist he would have been better prepared. This training on addressing conflict needs to go beyond working with clients as he was versed in that but not how to address conflict with other professionals.

Other participants talked about their desire to better understand the training of the professionals they were most often in conflict with, FCMs, GALs, and CASAs, in the hopes that it would shed led on the decision and recommendations of those professionals. This desire to better understand came from an attempt to better understand these professionals' perspective when it differed greatly from the therapist. This was one of the things expressed by Elizabeth when she discussed her struggles with a GAL who would not approve the already DCS-approved housing of her client. She wanted to try and get inside the GAL's head to figure out if this disapproval was based on the GAL's more privileged background or her training. She wanted to know if she was missing something that the GAL was training to see and just wasn't sharing well or was it something to do with this particular GAL and this particular case.

Other participants discussed wanting to know more about the FCM's training and what they were told about the home-based therapist's role as this too was a source of conflict at times. They believed if everyone had a better understanding of each other's role and training then certain conflicts could be more avoidable in the future because they would no longer be making assumptions about what each knows and could provide education to fill the gaps when necessary, ensuring that everyone is now on the same page. This speaks to the fact that each professional on the team, while part of the child welfare field, enters with their own professional socialization process based on their individual occupation or role on the team and the agency they represent. This is particular true in child welfare teams where the service providers and professionals are made up of paid and, in some cases like the CASA, unpaid/volunteer positions.

This study also has implications for education, particularly in MSW, MFT, and other master's level counseling programs where many future home-based therapists will earn their degrees, particularly around the decision-making process and the strategies utilized to regulate emotions and present recommendation and opinions to the team in a calm, professional manner. Some participants were able to make the connection between the work that they do with clients and how they engage with them and how they engage with team members when there is conflict. Even as they did this, it was clear they were not actually trained in this but were just taking what they learned about working with difficult or mandated clients and applied it to their fellow professionals on the team.

Taking the curriculum and practice knowledge/experience a step further and incorporating interprofessional collaboration techniques could benefit higher education programs and better prepare their graduates to enter a field where they are is an increasing expectation that they will collaborate with other professionals with various backgrounds and degrees. Focusing on particular parts of the model like the decision-making process and focusing on why, how, and when home-based therapists decide to act would be key element to add to discussions on interprofessional collaboration and conflict. Engaging students in scenarios and thought exercises around this process would prepare them and give them the required tools and mindset to tackle these issues when the inevitable conflict emerges in their practice. This would also shed light on some of the larger macro issues like funding, policy, and interagency relationships that may be missing in some curriculums and trainings. These issues not only impacted the decisions home-based therapists made but, in some cases, the reason for the conflict itself. If this education does not occur in higher education, it is up to local agencies to incorporate

these concepts into their orientation and training of employers or it is up the individuals themselves to seek continuing education in this field.

Finally, this study has large macro implications as well. It should be noted that these teams exist in a larger professional and political environment where they are judged by the end results and their ability to keep children safe. The political environment may be particularly important when looking at conflict due to system issues, as policies and bureaucratic barriers were cited as sources of conflict. Frustrations with lack of communication with team members was also a common occurrence which could be due to overworked team members which could be a result of policy in regard to case numbers or more systematic issues like high turnover and shortage of FCMs. In addition to this, the power dynamics between both the individuals on the team such as between the home-based therapist and the FCM and the agencies they represent also color the interactions of team members. Policies surrounding child welfare MDTs should be examined to ensure that they support collaboration and positive conflict resolution among the various team members from various sectors.

Future Research

This study could be the catalyst for future research. One such study could simply recreate this one but with other team members such as FCMs and GALs or CASAs. It would be interesting to see if these professionals experience conflict in the same manner or whether their role on the team makes their experiences different from the home-based therapists. This could provide more insight into the impact power may have on conflict in these teams, particular when examining the FCMs experiences, as they would not have to worry about the financial ties that home-based therapists had to consider when address

conflict. Examining how family members experience conflict in their teams and what it does to their progress, motivation, and opinions of those professionals tasked with working with them would be another important perspective to examine when it comes to conflict in child welfare MDTs.

It may also be beneficial to recreate this study in exclusively rural counties to determine if familiarity plays a role in addressing conflict. Since team members are more likely to work together more often in rural areas this could have some impact on the model. Another interesting study, and perhaps a means to test and refine the model, would be to replicate this study but put in inclusion criteria regarding experience, which was lacking in this dissertation study. As has previously been mentioned, participants who were newer to home-based therapy and the child welfare field were more likely to discuss feeling overwhelmed by conflict or unprepared for the speed at which matters were discussed in their team meetings. Additionally, many participants discussed learning from past conflicts and how that shaped their approach to current and future conflicts. Without as much experience, newer therapists have fewer examples to learn from and use as they face conflict. As such, conducting a study solely with therapists with less experience (perhaps less than 1-2 years) and another study solely with therapists who have more experience (perhaps 4 or more years), or doing a larger study with these sto subgroups to conduct a comparison analysis, would help shed light on any differences in conflict resolution strategies between newer and more experienced therapists. This might also test the model to see if it accurately captures the experience of home-based therapists, regardless of experience level.

Additionally, different states utilize different models of MDTs in their child welfare system. While this area utilized a model that resembled the Community Partnerships for Protecting Children model, other child welfare systems utilize a Family Group Conferencing model that has the family as the ultimate decision maker. Different models impact the decision-making process where conflict can commonly occur. Replicating this study with teams that use a different model like the FGC model would add a new dynamic to this study. It would be beneficial to conduct this study with team members who practice different models or approaches to MDTs to see if this alters the way they address conflict when it emerges or if it impacts the type of conflict they face within their teams.

Additionally, it could be beneficial to partner with the child welfare system and its service providers and families to be able to observe team meetings and shadow cases to be able to witness first-hand the conflict as a neutral observer. These observations could then be added to interviews where members could be asked about their thought process in the team meetings. By observing the team meetings, this study would not solely rely on the recall and perceptions of one particular team member. Observations could be used to fill in gaps related to recall bias. Also, by observing the team and how each member address conflict, their statements in interviews could be tested against these outsider observations. This study would add a unique perspective of real-time analysis of conflict and those involved in it.

Examining participants conflict management styles to see if a pattern emerges could also be beneficial for training purposes. This could be done with a mixed methods study were participants take a survey like The Rahim Organizational Conflict Inventory-

II (ROCI-II) (Rahim, 1983) which is a 28-item questionnaire using 5-point Likert scale responses ranging from strongly disagree to strongly agree. The scale is based on the five conflict management styles found in the Managerial Grid (Blake & Mouton, 1964). Researchers could analyze results to see which style participants use and then, through interviews, could see if that has any impact on the approaches they use to address conflict.

It may also be beneficial to have a better understanding of the frequency and amount of the issue of conflict with other team members. This could best be answered by quantitative methods. A larger study asking child welfare professionals their opinions of conflict with their teams, which other professionals they tend to find themselves in conflict with, and the causes of conflict could all be examined though surveys. Questions focusing on some of the more macro issues could also be included in a quantitative study or it could be done qualitatively to get in depth knowledge of how professional socialization impacts decision-making or views on team conflict for example. Finally, more could be done so this model could be tested and refined as needed so that it best captures the process in which conflict is addressed with child welfare MDTs.

Limitations

This study does have some limitations that should be acknowledge. Though many efforts like member checking, writing memos, and peer debriefing were utilized to increase the rigor of this study, and there is a strong level of trustworthiness, it should still be noted that as a qualitative study it is not generalizable. The goal, which was accomplished, was to provide a deep understanding of the process that home-based therapists go through when they experience conflict in their child welfare teams. The goal

was to not to provide a generalizable study, but it should still be pointed out that this study could perhaps be used as a launching point for such a study.

The sample size is appropriate for this study, but it consists solely of home-based therapists. While this sample provided the research with the needed data for the in-depth analysis needed, it does not examine the perspective of other key members of the team such as FCMs, GALs, and CASAs. This makes this study limited by nature as home-based therapist possess a specific role in the team that can come with certain levels of power and prestige among the team. This also means that each participant had similar professional socialization process as they became therapists. While they may have had different socializations through their agencies, they still represent the same profession. So even as the participants discussed actions of others on the team, they are presenting their interpretations or perceptions of their actions. It would have been beneficial to observe team meetings when conflict emerges to see how everyone responds as a neutral observer rather than rely on a member's observations. This study also does not address conflict with family members as the questions were limited to conflict with other professionals.

Another limitation to consider within this study is that participants were asked to remember conflicts they have experienced. Perhaps they had forgotten some details that could help shape the narrative. There is also the possible that they had forgotten about certain conflicts all together and these would have had added a new dynamic to the analysis. Many did report on active or ongoing conflicts which helped combat the fear that they had issues with recall, but it did limit the retelling of those conflicts to the where it was at the present time. Some participants were unable to talk about the resolution of the conflict because it had not yet reached that stage in the process at the time of the

interview. Additionally, even if they did remember all the details to a case they are still report on their actions and reactions to conflicts. They could misinterpret team members reactions or misjudge their own tones as they confronted conflict.

There is also the possibility that the participants ended up putting a positive spin on certain details to make sure that they were presented in a positive way by this researcher and future readers. No one likes to look like they were at fault or in the wrong when it comes to conflict, though some did admit this in their interviews. This could maybe explain why features of Edmund's (2010) communicative-affect conflict like the dirty fighting were not present in this study. The most a participant spoke negatively about themselves regarding how they handled conflict was Lily who described her conflict with an aggressive and combative therapist like a boxing match and stated that "I ended up in my corner with my client more than I probably should have been." Still there were no signs of bringing up past issues or making things personal with the therapist that she admitted too.

Conclusion

This study presents a unique model of how home-based therapists experience conflict with child welfare MDTs. This model follows the conflict from its emergence to conclusion showing home-based therapist reactions to it, how they make decisions on best ways to address it (or not), and then act. It also demonstrates that the team's response and decision dictate what the therapist will do next. In reviewing the literature, it is clear that issues related to MDTs and collaboration have been gaining popularity and rightly so. Conflict is also well studied in social work and many other fields. However, as it pertains to the child welfare system, the literature is not as abundant and focuses mainly

on the causes of conflict and some ways to avoid it. That is partly why I undertook this study because I wanted to learn more about the actual process team members go through when conflict emerges.

Understanding this process, and in particular how home-based therapists decide on a course of action and carry out their plan is an importance piece of understanding how these child welfare teams operate. With this knowledge the child welfare system can better prepare its professionals for the likely conflict they will encounter amongst themselves so that the family is not lost in any poorly managed conflicts.

Despite its limitations, this study and the creation of this model, accomplished what it sought out to do and adds to the understanding of conflict with child welfare teams. This understanding should not stop with this study though. Moving forward this model could be tested with different team members to see if it is role specific or more universal. It could also be tested in other areas and fields of social work and beyond where professionals of different backgrounds and disciplines work together to achieve a common goal.

In the end, this study demonstrates that there is a process that home-based therapists engage in when faced with conflict with their child welfare teams. They are strategic in their conflict resolution approach, keeping in mind their role of advocate for their clients as well as their professional ethics. Decisions and actions may happen quickly or slowly depending on the person but there is an internal dialog guiding their decision and their actions. Engaging in self-reflection is important throughout this process and teams that have established strong collaboration may be better equipped to address conflict when it emerges.

Appendix

Study Interview Form

Background Questions

Please fill out questions below and return to your interviewer.

GENDER: M F

AGE: _____

RACE/ETHNICITY (check all that apply)

___ White ___ Black or African American

___ American Indian or Alaska Native ___ Asian or Asian American

___ Native Hawaiian or Other Pacific Islander

Hispanic/Latino ___YES ___NO

Degree: _____ Year of Graduation: _____

License: _____

Other

Credentials:_____

Length of time as therapist: _____

Length of time as home-based therapist: _____

Length of time at current agency: _____

Length of time working with MDTs: _____

Length of time working within child welfare system: _____

Other agencies or roles with working within child welfare MDTs: _____

Interview Guide

I am interested in understanding how child welfare teams experience and manage conflicts. I know that conflicts are inevitable when groups of professionals work together in high-risk situations like child welfare. Therefore, I am going to ask you to describe at least one but up to five conflicts with as much detail as you can remember and share. First, I would like to talk about a conflict that stands out most in your mind. Then, if you are willing, I would like to discuss a conflict that you feel was resolved well and a conflict that you feel was not resolved well. I will be asking you about conflict between professionals on the team and then any conflict that involved the family. Before going into conflict though I would like to talk about collaboration.

So thinking about collaboration:

a. Can you tell me what promotes collaboration within the MDTs that you work with? (Where do these factors come from? – individual, profession, agency?)
b. What does collaboration look like to you?
c. What about barriers to collaboration, what factors make collaboration more challenging? (Where do these come from? – individual, profession, agency?)
d. How does collaboration (or lack thereof) impact your working relationship with other MDT members? With the family? How does it impact the case?

Let's now talk about the conflict and let's start with the one that stands out most in your mind

a. Take me back to the time that the conflict started and tell me what happened.

b. What happened next? And after that? What led up to the conflict? (Note: if needed, probe for who were the main players in the conflict, the setting in which it played out, the conversations that occurred related to the conflict, etc.)

c. Was the conflict resolved? If so, how? If not, why?

d. Remember back and tell me what you were thinking along the way as the conflict unfolded.

e. Remember back and tell me what you were feeling along the way as the conflict unfolded.

Now, let's talk about another conflict – one that you feel was resolved well.

a. Take me back to the time that the conflict started and tell me what happened.

b. What happened next? And after that? What led up to the conflict? (Note: if needed, probe for who were the main players in the conflict, the setting in which it played out, the conversations that occurred related to the conflict, etc.)

c. How was the conflict resolve? What were the steps? What were the outcomes?

d. Remember back and tell me what you were thinking along the way as the conflict unfolded.

e. Remember back and tell me what you were feeling along the way as the conflict unfolded.

Now, let's talk about another conflict – one that you feel was not resolved well.

a. Take me back to the time that the conflict started and tell me what happened.

b. What happened next? And after that? What led up to the conflict? (Note: if needed, probe for who were the main players in the conflict, the setting in which it played out, the conversations that occurred related to the conflict, etc.)

c. How was the conflict resolve? What were the steps? What were the outcomes?

d. Remember back and tell me what you were thinking along the way as the conflict unfolded.

e. Remember back and tell me what you were feeling along the way as the conflict unfolded.

Now, let's talk about conflict involving the family – one that you feel was resolved well.

a. Take me back to the time that the conflict started and tell me what happened.

b. What happened next? And after that? What led up to the conflict? (Note: if needed, probe for who were the main players in the conflict, the setting in which it played out, the conversations that occurred related to the conflict, etc.)

c. How was the conflict resolve? What were the steps? What were the outcomes?

d. Remember back and tell me what you were thinking along the way as the conflict unfolded.

e. Remember back and tell me what you were feeling along the way as the conflict unfolded.

Now, let's talk about another conflict – one that you feel was not resolved well.

a. Take me back to the time that the conflict started and tell me what happened.

b. What happened next? And after that? What led up to the conflict? (Note: if needed, probe for who were the main players in the conflict, the setting in which it played out, the conversations that occurred related to the conflict, etc.)

c. How was the conflict resolve? What were the steps? What were the outcomes?

d. Remember back and tell me what you were thinking along the way as the conflict unfolded.

e. Remember back and tell me what you were feeling along the way as the conflict unfolded.

Thank you for your time. That is all I had prepared for today in terms of questions but before we move on to a brief assessment is there anything else you would like to share or is there a question you think I should have asked but did not.

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Curriculum Vitae

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EDUCATION:

Indiana University, Indianapolis, IN Major: Social Work Minor: Sociology	PhD	May 2020
Indiana University, Indianapolis, IN Major: Social Work	MSW	May 2012
Saint Anselm College, Manchester, NH Major: Sociology	BA	May 2007

PROFESSIONAL HONORS AND AWARDS:

TEACHING

Award Name	Granted By	Date Awarded
Indiana University School of Social Work's Certificate of Recognition for the Excellence in Teaching	Indiana University School of Social Work	April 2018

SCHOLARSHIP

Award Name	Granted By	Date Awarded
University Fellowship	Indiana University Graduate School	August 2014

PROFESSIONAL DEVELOPMENT:

Theory, Practice, and Assessment of Social Work Teaching	Indiana University School of Social Work	Summer 2015
Certificate in College Teaching	Indiana University Purdue University Indianapolis Center of Teaching and Learning	Jan 2017 – May 2018
Level 1: NRMN Entering Mentoring Training	National Research Mentoring Network	2019

APPOINTMENTS:

NON-ACADEMIC

Family Works, Inc.	Home-Based Family Therapist	May 2012 – August 2014

TEACHING:

GRADUATE:

Course #	Short Title	Role	Term
S623	Practice Research Integrated Seminar	Adjunct Faculty	Spring 2017
S623	Practice Research Integrated Seminar	Adjunct Faculty	Summer 2017
S623	Practice Research Integrated Seminar	Adjunct Faculty	Fall 2017
S623	Practice Research Integrated Seminar	Adjunct Faculty	Spring 2018
S634	Group and Community Based Practice with Children and Families	Adjunct Faculty	Summer 2018
S502	Research I	Adjunct Faculty	Fall 2018
623A	Practice Evaluation: Introduction (1 credit) (Online)	Adjunct Faculty	Spring 2019
623B	Practice Evaluation: Application (2 credits) (Online)	Adjunct Faculty	Spring 2019
623A	Practice Evaluation: Introduction (1 credit) (Online)	Adjunct Faculty	Summer 2019
623B	Practice Evaluation: Application (2 credits) (Online)	Adjunct Faculty	Summer 2019
S634	Group and Community Based Practice with Children and Families	Adjunct Faculty	Summer 2019
S623	Practice Evaluation: Introduction (Online)	Adjunct Faculty	Fall 2019

S623	Practice Evaluation: Introduction	Adjunct Faculty	Fall 2019
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UNDERGRADUATE:

Course #	Short Title	Role	Term
S141	Introduction to Social Work	Adjunct Faculty	Spring 2018
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S141	Introduction to Social Work	Adjunct Faculty	Spring 2019
S141	Introduction to Social Work	Adjunct Faculty	Fall 2019

PUBLICATIONS:

Walsh, M.A. (2016). Paradigms found in reunification research. *Perspectives on Social Work, 12*(1), 7-14.

Jaggers, J.W. & **Walsh, M.A.** (2016). Qualitative analysis of the 2015 Cross System Youth Symposium: Technical guide to County Team Action Planning.

Walsh, M. A., & Jaggers, J. W. (2017). Addressing the needs of crossover youth: What key professionals are saying. *Children and Youth Services Review*, *75*, 110-115.

Philips, J.D. & **Walsh, M.A.** (2019). Teaming up in child welfare: The perspective of Guardians ad Litem on the components of interprofessional collaboration. *Children and Youth Services Review, 96,* 17-26.

PRESENTATIONS AT SCHOLARY CONFERENCES:

Walsh, M.A. (2015, May). A qualitative study of home-based therapists: Preliminary results using thematic analysis. Poster presentation at The 19th Annual Indiana University School of Social Work PhD Symposium, Indianapolis, IN.

Walsh, M.A. & Armstrong Richardson, E. (2016, April). Predictors of job satisfaction and intention to leave among child welfare services providers working within multidisciplinary teams. Poster presentation at The 20th Annual Indiana University School of Social Work PhD Symposium, Indianapolis, IN.

Walsh, M.A. (2016, November). Introducing a primary-care element to advanced practicum experiences: Lessons learned. Poster presentation at CSWE's 62nd Annual Program Meeting, Atlanta, GA.

Walsh, M.A. (2017, January). Challenges in implementing an additional practicum experience in primary care settings for advanced MSW students. Poster presentation at The 21st Annual Conference of the Society for Social Work and Research (SSWR), New Orleans, LA.

Walsh, M.A. & Armstrong Richardson, E. (2017, January). Predictors of job satisfaction and intention to leave among child welfare service providers working within multidisciplinary teams. Poster presentation at 21st Annual Conference of the Society for Social Work and Research (SSWR), New Orleans, LA.

Walsh, M.A. (2017, April). Introducing a primary care setting experience into advanced practicums: Lessons learned. Poster presentation at The 21st Annual Indiana University School of Social Work PhD Symposium, Indianapolis, IN.

Satre, C. & **Walsh, M.A.** (2017, October). Using focus groups to alter primary care practicum experiences for MSW students. Oral presentation at CSWE's 63rd Annual Program Meeting, Dallas, TX.

Walsh, M.A. (2017, October). The journey to home-based therapy: A qualitative case study. Poster presentation at CSWE's 63rd Annual Program Meeting, Dallas, TX.

Walsh, M.A., Jaggers, J.W., Satre, C, & Hall, J.A. (2017, November). Incorporating interprofessional collaboration into social work practicum experiences: Lessons learned. Panel discussion at The 2nd Annual Interprofessional and Education Conference, Indianapolis, IN.

Walsh, M.A., Jaggers, J.W., Satre, C, & Hall, J.A. (2018, January). Program modification: Using focus groups to alter primary care practicum experiences for HRSA fellows. Poster presentation at The 22nd Annual Conference of the Society for Social Work and Research (SSWR), Washington, D.C.

Walsh, M.A. & Armstrong Richardson, E. (2018, April). Learning on the job: A collaborative autoethnography of doctoral students during their first teaching experience. Poster presentation at The 22nd Annual Indiana University School of Social Work PhD Symposium, Indianapolis, IN.

Walsh, M.A., Jaggers, J.W., Satre, C, & Hall, J.A. (2018, November). MSW Students Views of Interprofessional Collaboration after First-Hand Experiences. Poster presentation at CSWE's 64th Annual Program Meeting, Orlando, FL.

Philips, J.D. & **Walsh, M.A.** (2018, November). Teaming up in child welfare: The perspective of Guardians ad Litem on the components of interprofessional collaboration. Poster presentation at CSWE's 64th Annual Program Meeting, Orlando, FL.

Walsh, M.A. & Armstrong Richardson, E. (2019, January). Becoming a professor: A collaborative autoethnography of doctoral students during their first teaching experience. Poster presentation at The 23rd Annual Conference of the Society for Social Work and Research (SSWR), San Francisco, CA.

Walsh, M.A. & Armstrong Richardson, E. (2019, March). Becoming a professor: A collaborative autoethnography of doctoral students during their first teaching experience. Poster presentation at The E.C. Moore Symposium, Indianapolis, IN.